ACKNOWLEDGEMENT & CONSENT

EVOLENT SURGICAL MANAGEMENT (ESM) IS AN EVOLENT SPECIALTY SERVICES, INC. BRAND NAME

SURGICAL PROCEDURE AND MEDICAL DEVICES

Evolent Specialty Services, Inc. has partnered with your health insurance plan, facility and doctor to provide implantable device(s), biologics or other covered tools and supplies that may be needed in your upcoming procedure. If any of these items are used in your surgery, you will receive a bill directly from Evolent for the portion of your health care coverage for the devices, biologics and related services and supplies used in your procedure that are subject to cost sharing, such as deductibles, copayments and coinsurance. This is separate from any bills you may receive from your doctor or facility.

PATIENT INFORMATION

By signing this form, I understand that:

- HIPAA permits healthcare providers and health insurance plans to use and disclose protected health information (PHI) for payment purposes without my authorization.
- Evolent's Notice of Privacy Practices provides information about how Evolent may use or disclose PHI and my rights regarding use of my PHI.
- To review Evolent's Notice of Privacy Practices, I can visit ESMpatient.com/hipaa.
- Evolent reserves the right to change its privacy policy as allowed by law.

PATIENT CONFIRMATION AND DESIGNATION

By signing this form, I hereby:

- Verify and confirm that I am legally authorized to consent to treatment and have done so or will do so with my treating provider.
- Verify and confirm that I am financially responsible for payment of any deductible, copayment and/or co-insurance that may be applied to the health care coverage of my upcoming procedure.
- If I check one or both of the boxes below, I authorize Evolent to communicate as described below.

☐ Evolent may leave voicemails on the contact numbers on file regarding my surgery, insurance claims, bills or statements and collection efforts.

☐ Evolent may speak with the following person on my behalf:

NAME (PRINT) _____ DATE OF BIRTH (FOR VERIFICATION PURPOSES) _____ RELATIONSHIP TO PATIENT _____

NAME OF PATIENT (PRINT) _____ PATIENT DATE OF BIRTH _____ PATIENT SIGNATURE _____ DATE _____

IF APPLICABLE, LEGAL REPRESENTATIVES SIGN BELOW:

I verify and confirm that I am the legal representative of the patient identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship documents, etc.) that I am legally authorized to act on the patient's behalf with respect to this form.

NAME OF LEGAL REPRESENTATIVE (PRINT) _____ SIGNATURE OF LEGAL REPRESENTATIVE _____ DATE _____

NAME OF WITNESS (PRINT) _____ SIGNATURE OF WITNESS _____ DATE _____