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BOTOX PATIENT ASSISTANCE℠ Program Re-Enrollment Notification

November 10, 2014

Kathy Kujawa, MD - Medical Doctor
Alexian Rehabilitation Hospital
Uberti Bldg 900 Biesterfield Rd # 610
Elk Grove Village, IL 60007

Service Request Number: AL000ZOP

Dear Kathy Kujawa, MD - Medical Doctor,

The BOTOX PATIENT ASSISTANCE℠ Program is pleased to have provided your patient, Paul Dulberg, with BOTOX® at no charge for the past year. After 10 months from the date of enrollment, we are required to review the patient's eligibility information to ensure that the patient continues to qualify for the program.

To re-enroll in the BOTOX PATIENT ASSISTANCE℠ Program, please complete the following steps.

1. Review the completed application for accuracy.
2. Ensure you and your patient sign the Certification and Consent Statement on the application form.
3. Include a copy of your patients (or guardian's) income documentation.

Acceptable forms of income documentation include one of the following:

- 1040, 1 040A, or 1040 from the most recent tax year
- W-2
- Social Security Statement

Should your patient receive coverage for BOTOX® through Medicare, Medicaid, or any other third party payer benefit, please notify the BOTOX PATIENT ASSISTANCE℠ Program immediately so that we can review your patient's eligibility.

Please remember that in order to comply with applicable laws and regulations, you agree not to bill or collect from the patient or any government or private payer, or to trade, sell, barter for or return for credit any visit you receive under this program. In addition, if you are unable to waive the administration fee, please be sure that your patient understands that these costs are his or her responsibility.

As a reminder, the patient is not eligible for consideration to participate in the BOTOX PATIENT ASSISTANCE℠ Program until we receive the necessary form and income documentation. If we do not receive the required paperwork by , your patient will be withdrawn from the patient assistance program.

Thank you for your continual support in helping financially needy patients to gain access to BOTOX®.

Sincerely,

BOTOX PATIENT ASSISTANCE℠ Program

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BOTOX PATIENT ASSISTANCE® Program Application Form

Date: «Date»

PROVIDER/SPONSOR INFORMATION

Provider Sponsor Name: Kelly Kujawa
Contact Person and Title: Kelly Kujawa
Address: Eberle Bldg 800 Elmhurst Rd # 610
City: Elk Grove Village State: IL Zip: 60007
Phone Number:
Fax Number:
Facility Name: Alexian Rehabilitation Hospital
○Physician's Office ○Hospital ○Other
License Number:
NPI:

Please provide contact person and address for product shipment (if different from above):

Provider Sponsor Name:
Contact Person and Title:
Address:
City: State: Zip:
Phone Number: ( )
Fax Number: ( )

TREATMENT INFORMATION

Diagnosis (ICD-9 Code):
Estimated Dose (in 100 Unit vials):

I certify that I have read the Sponsor Certification and Consent Statement in full and that I understand and agree to the terms stated in the Declaration by signing below.

Provider Sponsor's Signature (required)
Date Signed (required)

PATIENT INFORMATION

Patient Full Name: Paul Dalberg
Social Security Number:
Address: 4606 Hayden Ct
City: Mchenry State: IL Zip: 60050
Phone Number: (847) 497-8259
Date of Birth: 03/19/1970
Number of members in household:
U.S. Resident (including Puerto Rico and U.S. Territories): ○Yes ○No
Patient's annual gross household income: $
Income Source: ○1040 ○1040A ○1099 ○W-2 ○Social Security Statement

I certify that I have read the Patient Certification and Consent Statement in full and that I understand and agree to the terms stated in the Declaration by signing below.

Patient's Signature (required)
Date Signed (required)

Please provide documentation verifying your income by attaching a copy of your 1040, 1040A, or 1099 from the most recent tax year, W-2, or Social Security Statement.

INSURANCE INFORMATION

○Medicaid ○Medicare ○PO ○POS ○Indemnity ○Medicare ○Medicaid ○No Insurance

Primary Insurance Company:
Secondary Insurance Company:
Policy Number: Group Number:
Policy Number: Group Number:
Address:
Address:
City: State: Zip:
City: State: Zip:
Phone Number:
Phone Number:
Subscriber's Name: Date of Birth:
Subscriber's Name: Date of Birth:
Subscriber's Relationship to Patient:
Subscriber's Relationship to Patient:

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PLEASE READ DECLARATION BEFORE SIGNING FRONT OF FORM

PLEASE READ CAREFULLY BEFORE SIGNING

The BOTOX PATIENT ASSISTANCE® Program offers assistance to financially eligible patients who need BOTOX® treatment. Patients who are uninsured or underinsured and are unable to afford the cost of therapy may be eligible for enrollment. While Allergan makes every effort to grant aid when needed and appropriate, the program is limited to available resources and may be discontinued at any time, without further notice.

I certify that the use of BOTOX® is medically necessary and appropriate and that I will be supervising the patient's treatment accordingly.

I further certify that, to the best of my knowledge, the patient has no medical insurance coverage for BOTOX®, including Medicaid/Medicare or other public programs, and the patient has insufficient financial resources to pay for the prescribed therapy. I agree not to bill or collect from the patient or any government or private payer, or to trade, sell, barter for or return for credit any BOTOX® provided under the BOTOX PATIENT ASSISTANCE® Program.

I also certify that my patient understands that these costs are his/her responsibility if I am unable to waive the administration fee.

I agree that any BOTOX® I receive for the patient named in the application will be used only for this patient.

I also understand that Allergan Inc. reserves the right to modify or discontinue the BOTOX PATIENT ASSISTANCE® Program at any time, without further notice.

PATIENT APPLICATION AND CONSENT STATEMENT

Under this program, Allergan agrees to ship product to the sponsor for vials of therapeutic BOTOX® for patients who have met the requirements set forth by the BOTOX PATIENT ASSISTANCE® Program. All of the terms and conditions below must be met in order for a patient to be enrolled in the program.

- Patient must meet the eligibility criteria
- Sponsor must complete and sign the application
- Patient must complete and sign the application and provide income documentation

I understand that this patient assistance program provides BOTOX® at no charge and does not include the provider administration fee.

I verify that the information provided in this application is complete and accurate to the best of my knowledge and may be used by Allergan Inc. and/or its agent or authorized designee in determining eligibility to participate in the BOTOX PATIENT ASSISTANCE® Program. I understand that at such time as I obtain coverage or have the financial resources to pay for the cost of therapeutic BOTOX®, I will notify Allergan of such a change in my coverage status. I understand that I will be re-evaluated for eligibility for the BOTOX PATIENT ASSISTANCE® Program every 12 months.

I understand that, by my signature, any and all information that I provide may be shared with my treating provider.

By my signature, I agree that Allergan Inc. and/or its agent or authorized designee may contact my health care provider to request information concerning my medical condition and I hereby direct them to provide information relative to my medical condition or treatment or drug therapy, as requested. In addition, I agree that Allergan Inc. and/or its agent or authorized designee may contact my payer to obtain benefit information for therapeutic BOTOX®.

Allergan Inc. and/or its agent or authorized designee agrees not to disclose any information obtained from these sources to any third party except as provided herein or except as required by applicable law.

I also understand that Allergan Inc. reserves the right to modify or discontinue the BOTOX PATIENT ASSISTANCE® Program at any time, without further notice.

PATIENT INTEREST IN BOTOX® INFORMATION

- ☐ Yes, I am interested in receiving additional information about BOTOX®
- ☐ No, I am not interested in receiving additional information about BOTOX®

_____ _____

Patient's Signature (required) Date Signed (required)

® mark owned by Allergan, Inc.

BOTOX PATIENT ASSISTANCE® Program
PO Box 1376 San Bruno, CA 94066 · Phone: 800-44-BOTOX (Option 5) · Fax: (877) 539-6680

HIPAA AUTHORIZATION FOR THE USE AND DISCLOSURE OF PATIENT INFORMATION

I authorize my physician, _____ ("Physician") to give Allergan, Inc., any subcontractors or agents of Allergan, Inc. ("Allergan") information about me which is necessary to determine my eligibility for the BOTOX PATIENT ASSISTANT Program ("Program"), to administer the Program and to account for my withdrawal should I decide to stop participating in the Program. I understand that the type of information that can be given under this authorization may include my name, birth date, address, telephone number, social security number, income, prescription coverage, prescription for medication(s), financial documents and insurance records. I further understand that if my information is incomplete or the completed information does not allow me to participate in the Program that I may be notified of such by Allergan. I also understand that signing this authorization does not guarantee that I will be accepted into the Program. I further understand that because Allergan is not covered by federal privacy regulations, after my information is disclosed to Allergan, it will no longer be protected under federal law and could be subject to re-disclosure. This authorization will expire one (1) year after the date it is signed below, or one (1) year after the last date I receive medications under the Program, whichever is later. I may cancel this authorization at any time by providing written notice to Allergan at the address set forth below. My revocation will become effective on the date my written notice is received and processed by the Program and at such time I will no longer be qualified to receive medication assistance from the Program. I understand that my refusal to sign this authorization will not affect my ability to obtain treatment from my Physician, but that I will not be able to participate in the Program.

You are entitled to a copy of this authorization for your records.

_____ _____

Signature of patient or authorized person Date

_____

Relationship/Reason patient is unable to sign

ALEXIAN BROTHERS MEDICAL GROUP

printed 12/01/2016 09:58 AM

BONAVENTURE MEDICAL
FOUNDATION
PO BOX 5588
BELFAST, ME 04915-5500
billing phone: (847) 506-6622

GUARANTOR NAME AND ADDRESS	PATIENT #	PATIENT NAME
PAUL DULBERG 4606 HAYDEN COURT MCHENRY, IL 60051	315684	PAUL DULBERG
	DOB	HOME TELEPHONE
	03/19/1970	(847) 497-4250

Billing Summary

Claim ID	Procedure	Date of Service	Post Date	Type	Reason	Plan	Rendering Provider	Insurance Amount	Insurance Adjustment	Patient Amount
Claim ID 3612197										
3612197	99213	11/11/2016	11/14/2016	CHARGE	99213	AETNA BETTER HEALTH - FAMILY HEALTH PLAN (MEDICAID HMO)	KATHY KUJAWA	$119.00		
3612197	99213	11/11/2016	11/28/2016	PAYMENT	CHECK 00877475	AETNA BETTER HEALTH - FAMILY HEALTH PLAN (MEDICAID HMO)	KATHY KUJAWA	$-28.35		
3612197	99213	11/11/2016	11/28/2016	ADJUSTMENT	CONTRACTUAL	AETNA BETTER HEALTH - FAMILY HEALTH PLAN (MEDICAID HMO)	KATHY KUJAWA	$-90.65		
							OUTSTANDING	$0.00	$0.00	$0.00
							TOTAL CHARGE OUTSTANDING AS OF 12/01/2016	**$0.00**	**$0.00**	**$0.00**

ALEXIAN BROTHERS MEDICAL GROUP • 800 BIESTERFIELD RD, ELK GROVE VILLAGE IL 60007-3361

DULBERG, PAUL (id #315684, dob: 03/19/1970)

AMITA HEALTH
NEUROSCIENCES INSTITUTE

Date: 11/22/2016

RE: **Patient:** Dulberg, Paul
DOB: 03/19/1970
Address: 4606 Hayden Court
McHenry, IL 60051

Patient ID: 315684

To Whom It May Concern:

I am writing at the request of my patient, Mr. Paul Dulberg, after our most recent clinic visit on 11/11/16. During that visit, we discussed at length the IME from Dr. Craig Phillips at the Illinois Bone & Joint Institute completed on 10/4/16. Dr. Phillips wrote a very detailed, elegant and comprehensive review of Mr. Dulberg's orthopedic injury that occurred on June 2011. However, I was rather surprised and shocked at the paucity of neurologic input into Mr. Dulberg's evaluation.

A Movement Disorders neurologist, like myself, practices in a highly subspecialized field that includes Tourettes syndrome, Parkinsons disease, Essential tremor, and Mr. Dulberg's condition of dystonia. I completed an additional 2-year fellowship program at Rush Medical Center in Chicago, after my 4-year neurologic resident training period, and have been practicing exclusively in this field for the past 17 years. I do not know Dr. (?Karen) Levin, from the Associates of Neurology, but I can assume this physician is a general neurologist.

Dystonia is a rare neurological disorder, and can be easily missed by any physician who does not have the specific training or experience to recognize its symptoms. Therefore I ask that this information be considered in Mr. Dulberg's case.

Sincerely,

Electronically Signed by: KATHY KUJAWA, MD

KATHY KUJAWA, MD
ALEXIAN BROTHERS MEDICAL GROUP

DULBERG, PAUL (id #315684, dob: 03/19/1970)

Encounters and Procedures

Clinical Encounter Summaries

Encounter Date: 08/05/2016

Patient

Name	DULBERG, PAUL (46yo, M) ID# 315684	**Appt. Date/Time**	08/05/2016 10:00AM
DOB	03/19/1970	**Service Dept.**	ABMG - ALEXIAN NSI EMR
Provider	KATHY KUJAWA, MD		
Insurance	Med Primary: MEDICAID-IL: ILLINOIS DEPARTMENT OF PUBLIC AID Insurance # : 921912416 Med Cash: SLIDING FEE SCHEDULE - DISCOUNT Prescription: SURESCRIPTS LLC - This member could not be found in the payer's files. Please verify coverage and all member demographic information. details		

Chief Complaint

Followup: Organic writer's cramp
Followup: Acquired torsion dystonia

HPI

***HPI Text Box**
Reported by patient.

Notes:

Here with mother, last seen 2/11/16
Today is "pretty good" day.
He reports cramping is worse by the end of the day, only lasts seconds, could not tolerate Baclofen (sedation) in the past.
Requesting handicap parking placard (ok with me) since he has difficulty loading heavy groceries (dog food) into his car.
Pain still present, but improved with Neurontin

Vitals

Wt:	160 lbs 08/05/2016 10:14 am	**Ht:**	5 ft 8 in 08/05/2016 10:14 am	**BMI:**	24.3 08/05/2016 10:14 am
BP:	130/80 sitting R arm 08/05/2016 10:17 am	**Pulse:**	88 bpm regular 08/05/2016 10:17 am	**RR:**	18 08/05/2016 10:17 am
Pain Scale:	0 08/05/2016 10:14 am				

Allergies

Reviewed Allergies
NKDA

Medications

Reviewed Medications

alfuzosin ER 10 mg tablet,extended release 24 hr — 01/29/16 filled
1 tab daily
Internal Note: (for bladder)

gabapentin 300 mg capsule — 02/08/16 filled
takes 3 caps in am, noon & 4 caps at hs (up to 10 tabs/day)
Internal Note: (reports difficulty cutting the scored 600 mg tabs)

naproxen 500 mg tablet — 01/07/15 filled
1 tab at 6a & 6p PRN for neck pain

Neurontin 600 mg tablet — 11/06/14 prescribed
1.5 tabs at 8a and 12noon, and 2 tabs at bedtime; scored-tabs
Note: never started this strength due to concern of being too weak to cut the

MAKE CHECKS PAYABLE TO:
ALEXIAN BROTHERS MEDICAL GROUP
PO BOX 5588
BELFAST, ME 04915-5500

FOR ACCOUNT QUESTIONS CALL:
847-506-6622
DUE DATE: 10/14/2013
PAGE: 1 of 1

DATE	DESCRIPTION	CHGS/CREDITS	OUTSTANDING
PATIENT:	PAUL DULBERG		
09/25/2013	NEW PATIENT OFFICE EXAM-DETAILED PROVIDER: KATHY KUJAWA, MD	$ 153.00	
09/25/2013	CREDIT PATIENT PAYMENT - THANK YOU	$ -110.00	
	PATIENT BALANCE DUE -		$ 43.00

*** YOU ASKED FOR IT, YOU GOT IT! ***
WE NOW OFFER THE ABILITY TO MAKE ONLINE PAYMENTS! PLEASE VISIT MYALEXIANDOC.NET TO LOG INTO OUR PATIENT PORTAL. YOU CAN ALSO CONTACT THE BILLING DEPT., MONDAY-FRIDAY, 8:30AM – 4:00PM. PHONE # 847-506-6622 EMAIL: ABMGBILLING@ALEXIAN.NET

THANK YOU FOR SELECTING ABMG AS YOUR PROVIDER! PLEASE REMIT BALANCE NOW.

CURRENT	OVER 30 DAYS	OVER 60 DAYS	OVER 90 DAYS	OVER 120 DAYS	TOTAL ACCOUNT BALANCE	INSURANCE PENDING	CURRENT BALANCE DUE
43.00	0.00	0.00	0.00	0.00	43.00	0.00	43.00

CLOSING DATE: 09/26/2013
ACCOUNT NUMBER: 315684A380 7890

000000525-A

Billing Summary: DULBERG, PAUL #315684 (E#315684)

ALEXIAN BROTHERS MEDICAL GROUP

printed 02/26/2016 11:09 AM

BONAVENTURE MEDICAL FOUNDATION
PO BOX 5588
BELFAST, ME 04915-5500
billing phone: (847) 506-6622

GUARANTOR NAME AND ADDRESS	PATIENT #	PATIENT NAME
PAUL DULBERG 4606 HAYDEN COURT MCHENRY, IL 60051	315684	PAUL DULBERG
	DOB	HOME TELEPHONE
	03/19/1970	(847) 497-4250

Billing Summary

Claim ID	Procedure	Diagnosis	Date of Service	Post Date	Type	Reason	Plan	Supervising Provider	Ins. 1	Ins. 2	Patient
Claim ID 3028496											
3028496	99214	F488, G248	02/11/2016	02/16/2016	**CHARGE**	99214	FAMILY HEALTH NETWORK - APEX HEALTHCARE INC (MEDICAID HMO)	KATHY KUJAWA	$175.00		
								OUTSTANDING	$175.00	$0.00	$0.00
Claim ID 2824569											
2824569	99215	[illegible] (33384, 33379)	07/28/2015	07/29/2015	**CHARGE**	99215	FAMILY HEALTH NETWORK - APEX HEALTHCARE INC (MEDICAID HMO)	KATHY KUJAWA	$234.00		
2824569	99215	[illegible] (33384, 33379)	07/28/2015	01/12/2016	PAYMENT	CHECK 935849	FAMILY HEALTH NETWORK - APEX HEALTHCARE INC (MEDICAID HMO)	KATHY KUJAWA	$-54.75		
2824569	99215	[illegible] (33384, 33379)	07/28/2015	01/12/2016	ADJUSTMENT	CONTRACTUAL (136232)	FAMILY HEALTH NETWORK - APEX HEALTHCARE INC (MEDICAID HMO)	KATHY KUJAWA	$-179.25		
								OUTSTANDING	$0.00	$0.00	$0.00
Claim ID 2690356											
2690356	99215	[illegible] (33384, 33379)	03/10/2015	05/22/2015	**CHARGE**	99215	FAMILY HEALTH NETWORK - APEX HEALTHCARE INC (MEDICAID HMO)	KATHY KUJAWA	$234.00		
2690356	99215	[illegible] (33384, 33379)	03/10/2015	08/08/2015	PAYMENT	CHECK 919520	FAMILY HEALTH NETWORK - APEX	KATHY KUJAWA	$-48.00		