LINEAGEN INC., 423 WAKARA WAY, SUITE 200, SALT LAKE CITY, UTAH 84108
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Clinical Partnership Agreement Form

PLEASE INITIAL EACH ITEM AND SIGN/DATE THIS FORM AT THE BOTTOM.

By participating in this Clinical Partnership between Lineagen and the Dup15q Alliance, I agree to the information included in the test requisition as well as the following:

☐ The services provided by Lineagen will be billed to my (the responsible party's) insurance carrier. I will provide a copy of the front and back of my insurance card at the time of sample collection. I am aware that Lineagen is unable to accept and bill Medicaid/Medicare at this time.

☐ In exchange for providing my child's registry information and completion of follow up surveys, Lineagen will reduce my coinsurance by $650. I will be expected to pay any unmet in-network deductibles.

☐ I will provide Lineagen with assistance in the insurance follow-up billing/appeals process. This may involve providing copies of my child's medical records/previous test results to Lineagen and participating in telephone calls to my insurance company.

☐ Lineagen will have access to my child's genetic test information, Dup15q Alliance Registry information, medical records provided by my physician, and the surveys I complete for purposes of analysis, education, publication, and/or its intellectual property development ("Purposes"). A publication may be aimed at furthering the medical community's knowledge of Dup15q and related conditions and improving clinical management. Lineagen will abide by any existing or applicable confidentiality, HIPAA, and/or IRB requirements for such Purposes when applicable.

☐ I agree to allow Lineagen to provide my child's genetic test result directly to the coordinator of the Dup15q Alliance Registry.

To be filled out by the Responsible Party:

Child (patient)'s Name: ______________________________

Your Printed Name: ______________________________

Your Signature: ______________________________

Date: ______________________________