**USAGE GUIDELINES AND AUTHORIZATION FORM**

The Fisher Wallace Stimulator® is a wearable, safe neurostimulation device that is FDA-Cleared to treat depression, anxiety and insomnia.

Who May Authorize Patient Purchase: A healthcare practitioner licensed in the state that he or she practices.

FDA-Clearance Date: 1990  
Medicaid Approval Date: 2017

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**USAGE GUIDELINES**

The Fisher Wallace Stimulator® should be used for 20 minutes, twice-a-day (morning and evening). Patients with insomnia should use the device within two hours of bedtime.

If mood and sleep symptoms are reduced but do not go into remission within the first 30 days, patients may continue using the device on a daily basis.

If mood and sleep symptoms go into remission, patients may use the device on a “maintenance basis” three to four times per week, or on an “as needed basis.”

The device may be safely used in conjunction with drug therapy (such as antidepressants) or as a standalone therapy.

The device has been on the market since 1990 without reports of negative effects from long term use.

Discontinuing use of the device does not cause withdrawal symptoms.

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**CONTRAINDICATIONS**

Patients with pacemakers, implanted stimulators, or any other implanted electronic medical device should not use the Fisher Wallace Stimulator®.

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**POTENTIAL SIDE EFFECTS**

Temporary headache and dizziness occur in less than 1% of patients. These symptoms dissipate shortly after terminating use of the device.

Patients may return their device for a refund within 30 days of receipt, and may request an additional 30 days (60 days total) as needed.

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CALL FISHER WALLACE WITH ANY QUESTIONS: (800) 692-4380
AUTHORIZATION FORM FOR THE FISHER WALLACE STIMULATOR®

Date: _______/_______/_______

Practitioner’s Information
Practitioner’s Name: ___________________________________________________________________
Practitioner’s Address: ___________________________________________________________________
City: ___________________ State: ___________________ Zip code: ___________________
Phone Number: ___________________ Email: ___________________
State License Number: ___________________

I authorize the following patient to purchase the Fisher Wallace Stimulator®:

Patient’s Information
Patient’s Name: ___________________________________________________________________
Patient’s Address: ___________________________________________________________________
City: ___________________ State: ___________________ Zip code: ___________________
Phone Number: ___________________

HCPSC Code: E1399
Diagnosis Code(s): ___________________ Practitioner’s signature ___________________

Fax completed form to (800) 657-7362
OR
Email a photo of completed form to info@fisherwallace.com

FM-2033 Rev.8