FAIRFAX
Foot and Ankle Specialists

CONSENT FOR TREATMENT

By signing below, I hereby authorize FairfaxFoot and Ankle Specialists, PLLC to obtain medication history from community pharmacies and/or pharmacy benefit managers for the purpose of ongoing treatment. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary to the diagnosis and/or treatment of me or my child's condition. As a representative of myself or as a guardian, I give authorization for the above listed patient to receive medical and/or surgical care and treatment with Dr. Scholnick, DPM or any other doctor affiliated with Fairfax Foot and Ankle Specialists, PLLC. I understand that if I do not follow my doctor's instructions concerning my care and treatment, the outcome of my care and treatment could be put into jeopardy and less than optimal results may occur.

DESIGNATION DISCLOSURE FORM

We can not give out any medical information unless we have your written consent to do so. It is important for us to know who you would like us to give information to in case we receive a call. If you are a single parent it is most important to know if we can speak to the other parent of the minor child. By conveying to our staff the persons you would like us to speak to, you agree that the practice may disclose certain of your health information to a Personal Representative of your choosing, including payment information. If this information changes it is important for you to call our office immediately to update this list.

HIPAA COMPLIANCE

Per HIPAA compliance (Privacy Act) I give permission for Fairfax Foot and Ankle Specialists to leave detailed and personal medical information including lab, testing results, x-rays, appointment reminders, surgical procedure dates, etc. on my home answering machine or voicemail. I give permission to be contacted by the e-mail left on file. I understand I can revoke this authorization at any time.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been made aware of Fairfax Foot and Ankle Specialists, PLLC Notice of Privacy Practices. A paper copy is available at my request. The Privacy Policy sets forth the way in which my Protected Health Information may be used or disclosed and outlines my right with respect to such information. I also acknowledge that I have been allowed to ask questions. If I am not the patient, I represent that I am authorized by law to act for and on the patient's behalf. I understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plan for future care or treatment. I understand that this information serves as a basis for planning my care and treatment, a means of communication among the many health professionals who contribute to my care, a source of information for applying my diagnosis and surgical information to my bill, a means by which a third-party payer can verify that services billed were actually provided, and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals. By accepting services at Fairfax Foot and Ankle Specialists, PLLC, I authorize Fairfax Foot and Ankle Specialists to use and disclose information from and release copies of my medical records in accordance with Fairfax Foot and Ankle Specialists policies and privacy practices, including disclosure to my past, present and future healthcare providers. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices. By signing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP) to review and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices (NPP) and agree to its terms.

FAIRFAX
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AUTHORIZATION FOR ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment/assignment of insurance benefits directly to Fairfax Foot and Ankle Specialists. These payments will not exceed my indebtedness for services rendered. My signature authorizes payment for all major medical and/or durable medical equipment supplies and/or surgical benefits to which I am entitled from the listed insurer(s) above and/or by providing my insurance cards to the office to pay for services rendered to Fairfax Foot and Ankle Specialists. In the event that your insurance company should happen to send payment to you, the patient, we expect that you would forward it to our office to be applied to your balance. I certify that the information I have reported with regard to my insurance coverage is correct. I understand that personal information about me will be needed by the Doctor, and my insurance plan to determine and communicate what services or benefits are covered by my insurance plan, and to submit and process a claim for payment on services rendered and for the doctor to collect all fees owed for those services. Therefore, for the purpose of obtaining payment for services rendered, I give the doctor, my insurance plan, the Centers for Medicare and Medicaid Services (CMS), their agents, and and/or any other holder of information about me, authorization to release and/or exchange medical, billing, and collection information. This authorization is valid until I notify Fairfax Foot and Ankle Specialists, PLLC in writing that it is revoked and shall remain in effect until cancelled in writing by Fairfax Foot and Ankle Specialists. I agree to promptly pay any remaining balance due on all professional and medical services. I understand that I am financially responsible for co-insurance, co-pays, deductible or any other charges if not covered and paid by insurance. I further agree that Fairfax Foot and Ankle Specialists is authorized to act in my behalf in the endorsement of benefit checks made payable to me and/or Fairfax Foot and Ankle Specialists. I hereby authorize Fairfax Foot and Ankle Specialists to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all of my insurance claims and submissions. I permit a photocopy of this agreement, or an electronic facsimile thereof, shall be considered as effective/valid as the original. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Fairfax Foot and Ankle Specialists, for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance or this assignment.

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize Fairfax Foot and Ankle Specialists, PLLC to use and disclose my individually identifiable Protected Health Information ("PHI") in the manner described below. I understand that my PHI may be re-disclosed by the person or entity receiving it and that it then may no longer be protected by federal privacy regulations. State law may or may not prohibit re-disclosure by the person or entity receiving my PHI. I voluntarily agree to this authorization, and I understand that my health care will not be affected if I do not sign this form. I hereby authorize use of my PHI for the purpose of diagnosing, treating, consulting, and referral. I hereby authorize the disclosure of my PHI to insurance carriers and/or its representatives for processing claims. By my signature, I acknowledge that I have read and understand the Authorization for Use and Disclosure of Protected Health Information.

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FINANCIAL AGREEMENT AND INFORMATION RELEASE

Thank you for choosing Fairfax Foot and Ankle Specialists. We are committed to serving you with skill and high quality care. If you have medical insurance, we want to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our policy.

The Responsible Parties whose signatures appear below agrees as follows:

Individually Identifiable Health information: The Doctor(s), Associate Doctor(s) and staff of Fairfax Foot and Ankle Specialists, PLLC named on this form are authorized to medically treat the patient named on this form. Our office is authorized to collect, use and exchange individually identifiable health information (IIHI) consisting of the patient's past, present, future medical information and other personal information to treat the patient, communicate with the patient's other health care providers, seek payment and carry out necessary business functions. A patient may request to see IIHI pertaining to themselves, request copies, ask for corrections or amendments to the IIHI and request in writing restrictions on its future use.

Claim Submission: We have prepared this to help you understand the complexities of medical insurance, realizing how confusing it can be. To begin, we would like to highlight a misconception; medical insurance was not designed to pay for all medical care. Most contracts have limits and/or various degrees of payment.

All levels of payment by insurance companies, including allowed fees, usual and customary (UCR), are governed by the premiums paid. They have nothing to do with the actual charges by a physician. Our fees are based upon a combination of our cost, our time, and our constant dedication to supplying our patients with the highest quality medical care. The treatment recommended by our office is never based on what your insurance company will pay; your treatment should NOT be governed by your insurance contract.

Please understand that your insurance is a contract between you and the insurance company. It is ultimately your responsibility to understand your insurance contract, the benefits of your plan for all services and what you will be responsible for financially. Fairfax Foot and Ankle Specialists will make all reasonable attempts to obtain payment from your insurance company. We file as a courtesy to you, but your insurance company will not give us a guarantee of coverage. If your insurance company pays only a portion of your claim or rejects your claim, you and/or the policyholder should make an inquiry to your insurance company. Payment delays or rejection of your claim by your insurance company does not relieve the financial obligation you have incurred. If these attempts fail, you, the patient, are responsible for the charges, including the 20% co-pay for Medicare or any HMO or PPO co-pays. These fees are due when services are rendered. The balance of your claims are your responsibility. It is important for you to understand that regardless of what the insurance company tells you or our office, it is not a guarantee that they will make payment and it is subject to change when the claim is processed. Please remember your benefits are subject to change at your insurance companies discretion. You are ultimately responsible for payment for all services. If payment is not received from the insurance carrier or other responsible party in 45 days, you will be billed directly.

We will not become involved in disputes between you and your insurance carrier. We do provide your insurance carrier with information regarding your diagnosis and treatment. We do not get involved in such matters as disputes regarding deductibles, copayments, non-covered charges and "usual and customary" charges. If your insurance carrier does not provide payment within 45 days after treatment, you will be responsible for payment. Fairfax Foot and Ankle Specialists, PLLC is required in accordance with its contract with your insurer to collect from you deductibles and copayments at the time of service. We will try to determine your copay and how much of your yearly deductible under your policy has been met for the year. We will require that you pay any amount not covered by your insurance, such as un-met deductibles and copayments under your policy, on the day of service. Our policy is to collect it prior to seeing the doctor. If your plan requires you to pay co-insurance, you will be required to pay that. If needed, we are happy to work with you to arrange a payment plan.

The Responsible Parties agree to pay for all fees and charges for supplies, services and treatment that are incurred by the patient per the terms of this agreement. All charges shown on billing statements are agreed to be correct and reasonable unless disputed in writing within 30 days of the billing date. The Responsible Parties remain, jointly and severally, financially responsible for the patient until Fairfax Foot and Ankle Specialists, PLLC receives their notification in writing to the contrary. If the patient is currently a minor, their guarantee is continuing even after the patient reaches the age of majority.

We are happy to bill your insurance directly as a courtesy to you, however we must have a copy of the insurance card. You are responsible for giving Fairfax Foot and Ankle Specialists the correct insurance information at the time services are rendered. If you do not have your insurance card with you, full payment is due at the time of service. We accept cash, check, and most major credit cards. The Responsible Parties agree to notify Fairfax Foot and Ankle Specialists immediately of any changes in your insurance or coverage. It is not the responsibility of this office to check your insurance for every appointment. Please provide your insurance cards and a photo ID at your initial appointment that we can copy for your chart.

Not all services and/or fees are covered or paid for by the Responsible Parties' health plan. Therefore, the Responsible Parties agree to pay for all deductibles, co-payments, non-covered services, and any portion of covered services not paid in full by the plan and understand that such payments are due at the time of service or immediately upon presentation of the bill. All proceeds from the plan are assigned to Fairfax Foot and Ankle Specialists, PLLC when applicable. Payments to our office may not be withheld, delayed or excused for any reason; including the outcome of claims, the financial insolvency of the plan and/or their contracted intermediaries & medical groups. Responsible parties are strongly advised to monitor, and communicate with the plan to ensure that Fairfax Foot and Ankle Specialists, PLLC claims are paid promptly, since they, as Responsible Parties, are ultimately financially responsible for all amounts owed to our office.

In order for us to service your account and/or to collect any amounts you may owe, we, Fairfax Foot and Ankle Specialists, and our agents may contact you by telephone at any phone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide us to use. Methods of contact may include using pre-recorded or artificial voice messages and/or use of an automatic dialing device, as applicable.

Payment Options: Patients that do not pay their co-pay at time of visit may be charged an additional $5.00 statement fee. An additional $25.00 will be added to your statement if a check is returned for insufficient funds. Once we have a returned check for you, we may require that all future payments be with cash, money order, cashier's check or credit card. Our office accepts most credit and debit cards. Our office also accepts valid check or cash. Anytime a co-pay, deductible or balance is due, we will charge the fee to your credit card which will help to keep you at a zero balance and paid up in full with your credit card on file.

Credit Card on File: In an effort to reduce costs and unnecessary use of paper, we will be reducing the amount of statements we send out from our office in the mail. We may require a credit or debit card on file with our office. Statements are wasteful of paper, stamps, and envelopes and are not efficient. We have to be fair and apply the policy to all patients. We have wonderful patients and we know that most of you pay your balances. Unfortunately, this is not the case every time. You will receive a letter in the mail from your Insurance carrier that explains how much of your office visit they pay and how much you pay. This is called an Explanation of Benefits, or EOB. This letter tells you exactly, according to your health insurance coverage, how much of your health care bill is your responsibility and how much is the responsibility of your insurance to pay. We receive the same letter that you do. It arrives typically within a few weeks after your last appointment. We look at each Explanation of Benefits (EOB) carefully, and determine what your insurance has determined as patient responsibility. This is the same way we normally determine how much to send you a bill for in the mail. You will be required to sign a credit card on file authorization statement that will allow us to charge an amount agreeable to each of us until your balance is paid in full. We will only charge the amount that we are instructed to by your insurance carrier, in the letter they send to us and the amount that you have agreed to, in the same way that we normally determine how much to send you a bill for in the mail.

Collections: All accounts must be paid by the receipt of the first two statements. If your account has not been settled either by payment in full or by contacting our billing department to set up a payment plan we will be charging a $10 re-billing fee for each additional statement sent. Your account will be turned over to collections if you do not fulfill the terms of your financial arrangements.You are responsible for all balances not paid by your insurance carrier, including deductibles, co-pay, and co-insurance and out of network penalties. In the event you do not satisfy your financial responsibilities, the practice may use a collection agency and may provide protected health information to that agency. If such agency is used, you will be responsible for a 35% balance-based collection fee and any additional costs related to satisfying that debt, including, but not limited to, court costs, and/ or reasonable attorney fees that may be incurred in the collection of an outstanding balance affiliated with satisfying your financial responsibility. If this balance is turned over to an outside agency, you shall be liable for all costs of attorney fees and/or court costs incurred by this office.

Uninsured/Self Pay: Payment in full is due at the time of service if you do not have health insurance. We are committed to provide the best treatment possible for our patients and we charge what is usual and customary for our area. If we do not have a contract with your insurance company, you are responsible for payment in full regardless of any insurance company's arbitrary determinations of usual and customary rates.

Non-Contracted Insurance (Out of Network): If you have an insurance plan that we do not participate with, you may have out-of-network benefits. These benefits typically have a higher copay, coinsurance, and/or deductible out of pocket cost. You will be considered a self-pay, uninsured patient if you do NOT have out of network benefits.

MEDICARE: We are a participating Medicare provider. Medicare as well as your secondary insurance (if any) will be billed for you. However, that does not mean that all services are covered. As a Medicare patient, you are responsible for paying their annual deductible if it has not yet been met and to pay for services not covered by your Medicare insurance. You are also responsible for any coinsurance, which is usually 20% of the allowed amount for an item or service. You will be required to sign an Advanced Beneficiary Notice for non-covered services or services thought to possibly not be covered.

COPAYMENTS, COINSURANCE and DEDUCTIBLES: All patients are responsible for and required to pay their co-pay, co-insurance, deductibles that are part of their insurance contract and any patient balances owed of all visits,at the time of their visit. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. We have no control as to what they put to your responsibility. Due to our contract with the insurance companies we are not at liberty to adjust off balances for co-pays, deductibles and co-insurance rates.

Please help us in upholding the law by paying your co-payment at each visit. We participate in a number of health insurance plans, including Medicare. If we do not participate with your insurance company, you will be responsible for full payment. If you are insured by a plan we participate with, but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Balances accumulated due to patient failure to provide our office with up-to-date insurance information every visit resulting in rejection of claims, will be passed on to the patient who will be responsible for full payment.

HMO/PPO: All co-payments are due at the time of service. We are members of most, but not all plans. You are responsible for verifying that we are providers for your plan. If you are an HMO member, you agree to provide Fairfax Foot and Ankle Specialists with any necessary referrals required. Please note: You must have your valid referral from your primary care physician at the time of the visit or your plan requires that we ask you to reschedule or you will be responsible for full payment prior to being seen by the Doctor. PPO patients will only be responsible for their deductible, co-payments and co-insurance, as long as they have verified with their insurance that our physician is in their plan.

SECONDARY INSURANCE: If you have more than one insurance we will bill your secondary insurance one time as a courtesy.Your medical claim will be forwarded to your secondary insurance (if any) after payment and/or explanation of benefits (EOB) is received from your primary insurance company. If payment is not received from your secondary within 45 days the balance becomes your responsibility.

Referrals/Authorizations: We are required to follow the guidelines of your managed care plan which mandates us that when you visit a specialist such as ours, you must have a referral from your primary care physician prior to seeking specialty care. Obtaining referrals from your primary physician and keeping track of your visits is your responsibility. If you do not have a valid referral at the time of your visit, your appointment with be rescheduled or you will be responsible for changes not covered by my Insurance due to my failure to obtain the required referral.

Non-Covered Services/Verification of Benefits: All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered" or you do not have an authorization, you will be responsible for the entire charge for all services rendered. We will attempt to verify benefits for some specialized services; however you remain responsible for charges to any service rendered regardless of what the insurance has told you or Fairfax Foot and Ankle Specialists. There are many cases when a patient calls their respective insurance to verify benefits and the insurance company mistakenly verifies that a service is covered. However, when the physician's office submits the claim, it is not covered. In this scenario, the patient is still ultimately responsible for full payment. Patients are encouraged to contact their insurance company for clarification of benefits prior to services rendered. Please remember that verification of coverage is not a guarantee of benefits. Actual plan coverage and benefit payments are determined when a claim is received. If your insurance company denies payment, you will be responsible for payment

Workers' Compensation: If you are here because of a work related injury, we will require information regarding both health insurance and your employer's Workers' Compensation insurance. Before seeing a doctor, we will require a letter or statement from the Workers' Compensation carrier authorizing your treatment. The letter should include the claim number, address, adjuster's name and phone number. (Your employer's human resources office should be able to assist you with obtaining this information.) If payment is not received from these third parties within 90 days, we have the right to bill you directly.

Hospital and Surgery Center Charges: In the event that you undergo surgery in a hospital or ambulatory surgery center, a separate charge will be made by that facility.

Copies of Medical Records: A minimum of 5 business days notice is required for copies of medical records or x-rays and there will be a nominal fee which is supported by federal law. Your original x-rays are property of the practice, but you can request copies for a fee and must allow adequate time to obtain these copies.

Custom Medical Equipment: In order to provide you with the best possible treatment, your doctor may prescribe a customized orthotic, brace, shoe or other durable medical equipment. This payment is non-refundable due to the nature of the device being made specifically to your foot, ankle or leg.

Missed Appointments/No Shows: Our office reserves the right to impose a $40 fee for missing an appointment or canceling within less than 24 hours. The reason for this is to encourage our patients to take their appointments as seriously as we do. That time is reserved for you and if you do not keep your appointment then other patients who are in need of an appointment for medical care are being obligated to wait longer than necessary.

Unaccompanied Minors: The parents or guardians will be responsible for full payment unless covered by a participating managed plan. Authorization to treat an unaccompanied minor must be on file.

Disability Forms: The nominal fee of $40 will be charged for the completion of disability forms.

Release of information: I hearby authorize the release of my medical information and to my insurance carrier, my primary care physician, and any consulting physician as part of the normal process in the delivery of healthcare and to process my claims. I also authorize Fairfax Foot and Ankle Specialists and the staff to collect information from any healthcare facilities, physicians or insurance carriers.

Financial Agreement: I understand that I am financially responsible for all charges not covered by insurance and I guarantee the balance to be paid by my credit card, check or cash. Past due balances may be subject to additional fees.