FAIRFAX
Foot and Ankle Specialists

Please initial next to each of the following document names to indicate that you have received, read and agree with the terms of each policy.

Initials:

_____CONSENT FOR TREATMENT

_____AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

_____AUTHORIZATION FOR ASSIGNMENT OF INSURANCE BENEFITS

_____FINANCIAL AGREEMENT AND INFORMATION RELEASE

_____HIPAA COMPLIANCE

_____ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

_____DESIGNATION DISCLOSURE FORM

By signing below, I acknowledge that I have received, read, understand and agree to all the aforementioned terms of all the listed policies initialed above

Signature of Patient/Guardian _____Date_____

Print Name_____

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Balances

Per the Financial Agreement, I agree and authorize Fairfax Foot and Ankle Specialists, PLLC to charge the credit or debit card on file to pay all outstanding balances including deductibles, co-insurance, co-payment, non-covered products or services, out of network penalties and any portion of covered services not paid in full by your health insurance plan. The office will only charge the amount instructed based on the Explanation of Benefits from my insurance company. If I do not want my card charged automatically to pay my balance, I will inform the doctor or staff of a payment plan or another form of payment. However, if I make no attempt to contact Fairfax Foot and Ankle Specialists, PLLC for payment I understand my card on file will be charged the total balance or sent to collections.

I understand if I have an unpaid balance to Fairfax Foot and Ankle Specialists, PLLC and do not make satisfactory payment arrangements, my account may be placed with an external collection agency. I will be responsible for reimbursement of the fee of any collection agency, which may be based on a percentage at a maximum of 35% of the debt, and all costs and expenses, including reasonable collection and attorney's fees incurred during collection efforts

In order for Fairfax Foot and Ankle Specialists, PLLC or their designated external collection agency to service my account and where not prohibited by applicable law, I agree that Fairfax Foot and Ankle Specialists and the designated external collection agency are authorized to (i) contact me by telephone at the telephone number(s) I am providing, including wireless telephone numbers, which could result in charges to me, (ii) contact me by sending text messages (message and data rates may apply) or emails, using any email address I provide and (iii) methods of contact may include using pre-recorded/artificial voice message and/or use of an automatic dialing device, as applicable.

Signature of Patient/Guardian _____Date_____

Print Name_____

Thank you for being one of our highly valued patients