HIPAA PRIVACY AUTHORIZATION FORM

To Our Valued Patients:

We strive to achieve the very highest standards of ethics and integrity in performing services for our patients. It is our policy to properly determine appropriate uses of Personal Health Information (PHI) in accordance with governmental rules, regulations, and laws. We want to ensure that our practice never contributes in any way to growing improper disclosure of PHI. As part of this plan, we have implemented a compliance program that we believe will help us prevent any inappropriate use of PHI. You have the right to review our privacy notice, to request restrictions, and to revoke the consent in writing after you reviewed our privacy notice.

I authorize Maryland Foot and Ankle Restoration, LLC and Belcrest Surgery Center, LLC to use and disclose my PHI to the following individuals:

- Any member of my family
- Only with the following individuals: _____
- I do not give permission to share any of my medical information

The authorization for release of information covers the period of health care from:

- Until canceled by me in writing
- From ____/____/____ to ____/____/____

The person(s) may use this medical information for medical treatment or consultation, billing, or claims payment, or other purposes I may direct. I understand that I have the right to revoke this authorization, in writing, at any time.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that information disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state.

Patient's Name and/or Authorized Representative: _____

Relationship to Patient: _____

Patient's Signature and/or Authorized Representative's Signature:

_____

Date Signed: ____/____/____

Maryland
Foot & Ankle
Restoration, LLC

Office Policies/Payment Acknowledgement/Financial Obligation

Your clear understanding of our policies is important to our professional relationship. We are pleased to discuss and answer questions or concerns regarding our policy, fees, and your financial responsibility at any time requested.

I understand, accept responsibility, and agree that:

- **By law,** we must collect Copays/Coinsurances and unmet deductibles. All Co-pays/Coinsurances and Deductibles are due at the time of service. Benefits are checked in real-time to determine the status of deductibles and out-of-pocket maximums. In the event that claims process differently than anticipated, this may result in under collection or overpayment. If this occurs, our office will bill for balances or provide refunds per our refund policy.
- Refunds will be issued via check from our bank after claims from all dates of service are finalized.
- Self-pay patient payments are required at time of service.
- I must give 24-hour cancellation/reschedule notice. **If I do not provide at least 24-hour notice of canceling/rescheduling my appointment, I will be charged a $50 missed appointment/late cancellation fee. Also, please note our surgery center policy: a $500 no-show fee for our facility Belcrest surgery center, LLC that will be charged to patients without a 1 week prior notification to cancel a scheduled surgery.**
- A $50 fee will be assessed on returned checks.
- Any patient under the age of 18 must be accompanied by an adult or they will not be seen.
- **In/Out of Network Plans: It is my responsibility to verify my benefit coverage and I am responsible for any balance my plan indicates as on their explanation of benefits.**

- If a referral is required by my plan from my PCP, it is my responsibility to obtain the referral prior to my appointment to bring in the day of service**. If I do not have referral, I will be responsible for any services received and not pre-authorized.**
- Divorced/Separated Parents of Minor Patients: Maryland Foot & Ankle Restoration, LLC will not be involved with separation disputes.
- There is a per-page fee for medical records and medical forms for school/work/sports/daycare providers/disability/FMLA, etc.
- I agree to receive text and email notifications from the practice to communicate information.

Patient/Guardian (print) _____ Date _____

Patient/Guardian (signature) _____Relationship _____

TODAYS DATE_____
Patients full name:
Last_____First_____MI_____Sex M F
Patient SS#_____Date of Birth_____
Marital Status S M D W Name of Spouse_____
Phone_____Work_____Cel_____
Local Address_____
City_____State_____Zip_____
Pharmacy #_____E-mail_____
Employer_____Occupation_____
Name and relationship of Emergency Contact_____
Phone number of Emergency Contact_____
Name of Family Physician_____Date last seen:_____
Phone_____ Preferred Language ____ English _____ Spanish _____ Other

_____ _____
SIGNATURE OF RESPONSIBLE PARTY DATE
Who can we thank for referring you?_____
PLEASE PROVIDE ALL INSURANCE CARDS TO THE RECEPTIONIST FOR COPYING

AUTHORIZATION FOR TREATMENT, ASSIGNMENT, AND RELEASE
I hereby give Maryland Foot & Ankle Restoration, LLC and Belcrest Surgery Center, LLC permission to treat my foot and/or ankle disorder. I, the undersigned, have insurance coverage with and assign directly to Maryland Foot & Ankle Restoration, LLC and Belcrest Surgery Center, LLC all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. hereby authorize Maryland Foot & Ankle Restoration, LLC and Belcrest Surgery Center, LLC to release all information necessary to secure the payment benefits. I authorize the use of this signature on all my insurance submissions.

_____ Date _____
Signature of Patient/Guardian

MEDICARE AUTHORIZATION FOR TREATMENT, ASSIGNMENT, AND RELEASE I hereby give Maryland Foot & Ankle Restoration, LLC and Belcrest Surgery Center, LLC and staff permission to treat my foot and/or ankle disorder. I, the undersigned,

request that payment of authorized Medicare benefits be assigned directly to Maryland Foot & Ankle Restoration, LLC and Belcrest Surgery Center, LLC for services furnished to me. I understand that by my signature, I request that payment be made and authorize the release of medical information necessary to pay the claim. If I have secondary insurance, my signature authorizes the release of all necessary information requested by the insurance company. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible for deductibles, coinsurance, and non-covered services. Coinsurance and deductibles are based upon the charge determination of the Medicare carrier. I authorize the use of this signature on all my insurance submissions.

_____Date _____

Beneficiary Signature/Guardian

NOTICE OF PRIVACY PRACTICES, OFFICE PAYMENT POLICY & RELEASE OF MEDICAL INFORMATION I acknowledge I have read and understand the Notice of Privacy Practices and a copy is available upon my request. I understand that unpaid balances 30 days from the invoice date will accrue 1.5% interest per month. I understand that a $5 reprocessing fee will be applied to each additional invoice issued on unpaid balances over 30 days. I understand that that if I have an unpaid balance that is sent to collections, I am responsible for the unpaid balance, an additional ½ of the unpaid balance to cover attorney's fees, and all court fees. I hereby agree to waive the defense of statute of limitations as it pertains to any claim filed against me beyond three years after services were rendered. I understand that a $50 fee will be assessed on returned checks. I understand that a $50 fee will be assessed for missed appointments that are not canceled or changed within 24 hours. I give Maryland Foot & Ankle Restoration, LLC and Belcrest Surgery Center, LLC permission to obtain and release medical information to referring physicians, insurance companies and attorneys requested these records. I authorize the use of this signature for today's visit and all future visits. I acknowledge that I have read the office policies of the Maryland Foot & Ankle Restoration, LLC and Belcrest Surgery Center, LLC that are available in our office.

_____ Date _____

Signature of Patient/Guardian

I understand that all durable medical equipment (DME) and retail items dispensed to me are nonrefundable and cannot be returned unless there is a factory defect with the product: At which time Maryland Foot & Ankle Restoration, LLC in Maryland will replace the defective item with a new item.

PATIENT CONSENT TO ELECTRONICALLY OBTAIN AND IMPORT PRESCRIPTION MEDICATION HISTORY

I authorize this practice and its healthcare providers to electronically obtain, access, and import my prescription medication history from pharmacies, pharmacy benefit managers (PBMs), health information exchanges, and other authorized healthcare sources as permitted by applicable law.

I understand that this information will be used to support my medical care, including reviewing my current and previous medications, improving medication safety, helping prevent drug interactions, and maintaining an accurate medical record.

I understand that my prescription medication information will be kept confidential and protected in accordance with applicable federal and state privacy laws, including the Health Insurance Portability and Accountability Act (HIPAA). I understand that I may revoke this authorization at any time by providing written notice to the practice, except to the extent that action has already been taken in reliance on this consent.

By signing below, I acknowledge that I have read and understand this authorization and voluntarily consent to the electronic retrieval and import of my prescription medication history into my electronic health record.

_____ Date _____
Signature of Patient/Guardian

CONSENT TO USE OF AMBIENT ARTIFICIAL INTELLIGENCE (AI) FOR CLINICAL DOCUMENTATION

To help improve the accuracy and efficiency of documenting your visit, our practice uses an Artificial Intelligence (AI) ambient documentation tool integrated with our NextGen® electronic health record (EHR) system. This technology securely listens to the conversation between you and your healthcare provider during your visit and generates a draft of the clinical note for your provider's review.

Your healthcare provider reviews, edits as needed, and approves the documentation before it becomes part of your permanent medical record. The AI system is used solely to assist with clinical documentation and does not make medical decisions or replace the judgment of your healthcare provider.

By signing below, you acknowledge and consent to the use of Ambient AI during your appointment. You understand that:

- The AI technology is used only to assist with documenting your medical encounter.
- Your healthcare provider remains responsible for reviewing, editing, and approving all documentation.
- Your information is protected in accordance with applicable federal and state privacy laws, including the Health Insurance Portability and Accountability Act (HIPAA).
- You may decline the use of Ambient AI at any time. If you choose not to consent, your healthcare provider will document your visit using standard documentation methods, and your decision will not affect your care or treatment.

_____ Date _____
Signature of Patient/Guardian

Consent for Communication

By opting-in to Email or SMS communication, you agree to receive communications from the practice including (but not limited to):

- Appointment reminders (message frequency varies)
- Post-visit surveys
- Messages to coordinate your healthcare

Message and data rates may apply. Reply "HELP" for support or "STOP" to opt-out at any time.

Information provided will not be shared with third parties for marketing purposes.

For more details, please refer to the attached **Privacy Policy and Terms and Conditions** starting on page 3.

Opt-In: ___ Email ___ Text

Acknowledgment and Signature

By submitting this form and signing below, I consent to receive informational text messages from Maryland Foot & Ankle Restoration, Llc at the number provided, including messages sent by autodialer. Consent is not a condition of purchase. Message & data rates may apply. Message frequency varies. Unsubscribe at any time by replying STOP. Reply HELP for help.

I confirm that I have read and agree to the terms outlined in the **Privacy Policy and Terms and Conditions,** which are included as part of this form. I also understand my rights to opt-out of communications at any time.

Patient Signature: _____ **Date**: _____

Privacy Policy & Terms and Conditions

Effective Date: August 14, 2026
Last Updated: August 14, 2026

Introduction

Maryland Foot & Ankle Restoration, Llc respects your privacy and is committed to protecting your personal information. This Privacy Policy explains how we collect, use, and protect information related to our messaging campaigns in compliance with A2P 10DLC requirements and applicable regulations.

Information We Collect

Opt-in Data: When you provide consent via our intake form by ticking the opt-in box, we collect:

- Your name
- Your phone number and/or email address
- The method of opt-in (e.g., web form, SMS keyword)

Message Interactions: Details of your interactions with our messages, such as confirmations, HELP requests, and STOP requests.

Device and Usage Data: Non-personally identifiable information, such as device type, message delivery status, and message interaction frequency.

How We Use Your Information

We use your information to:

- Deliver messages you have opted in to receive, including appointment reminders, surveys, or other informational updates.
- Respond to HELP requests and provide support.
- Ensure compliance with STOP requests to cease further communications.

Note: Your information is never shared with third parties for marketing purposes.

Subscriber Consent and Disclosures

By opting in via our intake form, you agree to:

- Receive recurring messages related to the service(s) provided.
- Acknowledge that "Message and Data Rates May Apply."
- Access HELP instructions and STOP options.
- Be informed that message frequency may vary depending on the program you subscribe to.
- Confirm that you are at least 18 years old (or the age of majority in your jurisdiction) if the content is age-restricted.

The opt-in process includes:

- A clear description of the type of messages you will receive.
- Disclosure that message frequency may vary.
- References to our Privacy Policy and Terms & Conditions, which are attached below.
- Confirmation of age eligibility, where applicable.

Age Disclosure

For campaigns involving age-gated content, users must confirm they meet the required minimum age before subscribing. By opting in, you confirm that you:

- Are at least 18 years old (or the age of majority in your jurisdiction).
- Understand that age-restricted content will only be sent to eligible subscribers.

Message Frequency

The frequency of messages you receive may vary depending on the service or program you have opted into. For example:

- **Appointment Reminders:** Typically 1–3 messages per appointment.
- **Promotional Updates or Informational Messages:** Up to 5 messages per month.

Specific frequency details will be disclosed at the time of opt-in. If you have further questions, reply "HELP" or contact our support team.

Opt-out Instructions

You may opt out of receiving messages at any time by replying "STOP" to any message. Upon opting out:

- You will receive a confirmation of your opt-out request.
- No further messages will be sent unless you re-opt-in.

HELP Requests

To request assistance, reply "HELP" to any message, or contact us directly through the following channels:

- **Email:** mfar@mfarestoration.com
- **Phone:** (301) 699-5900

Embedded Links and Phone Numbers

Messages may contain embedded links or phone numbers to direct you to secure resources, such as:

- Appointment confirmation pages
- Support contact information

All embedded links comply with security standards to protect your data.

Data Protection and Retention

We implement robust security measures to protect your data from unauthorized access or disclosure. Information is retained only as long as necessary to fulfill the purposes outlined in this policy or as required by law.

Compliance with A2P 10DLC Guidelines

Maryland Foot & Ankle Restoration, Llc adheres to the following A2P 10DLC requirements:

- **Subscriber Opt-in:** Opt-in details are clearly disclosed during the intake process, including brand name, message frequency, and opt-out/HELP information.
- **Subscriber Opt-out:** STOP instructions and confirmation messages are provided upon opting out.
- **HELP Information:** Patients can request help by texting HELP or contacting the office by phone.
- **Privacy Assurance:** Opt-in data is never shared with third parties for marketing purposes.
- **Sample Messages:** All messages identify the brand and include opt-out instructions.

Contact Us

For questions about this Privacy Policy, you can contact us at:

- **Email:** mfar@mfarestoration.com
- **Phone:** (301) 699-5900

Sample Messages

1. **Opt-in Confirmation:** *"Thank you for opting in to receive messages from Maryland Foot & Ankle Restoration, Llc. Message frequency may vary. Msg & data rates may apply. Reply HELP for support. Reply STOP to cancel. By opting in, you confirm you are at least 18 years old."*
2. **HELP Response:** *"Thank you for reaching out to Maryland Foot & Ankle Restoration, Llc. For assistance, please call us at (301) 699-5900 or email us at mfar@mfarestoration.com. Reply STOP to cancel messages."*
3. **STOP Confirmation:** *"You have successfully opted out of messages from Maryland Foot & Ankle Restoration, Llc. You will receive no further messages."*
4. **Survey Message:** *"Hi {{patient-first-name}}, would you please take a minute and write a review for us here: {{review-url}}. It would help other patients just like you know how we are doing! Thank you!"*
5. **2FA:** *“Your verification code is: {{code}}”*
6. **Customer Care:** *“Hi {{patient-first-name}}. Please reply “C” to confirm your appointment on {{appointment-formatted-date-time}} with Maryland Foot & Ankle Restoration, Llc. Please reply back to this message if you have any questions. More details on {{appointment-details-url}}. Thank you! You may Reply 'STOP' at any time to stop receiving future messages.”*

7. **Customer Care:** *“Dear {{patient-first-name}}. Just a friendly reminder that you have an appointment on {{appointment-formatted-date-time}} with us at Maryland Foot & Ankle Restoration, Llc. For driving directions, click here: {{practice-location-formatted-address}}. Please reply back to this message if you have any questions or need to reschedule. Thank you!”*

TERMS AND CONDITIONS

You agree to receive informational messages (such as appointment reminders, account notifications, and other updates) from Maryland Foot & Ankle Restoration, Llc. Message frequency varies depending on your interactions and service subscription. Standard message and data rates may apply. For help, reply HELP to any message or email us at mfar@mfarestoration.com. You can opt out of receiving messages at any time by replying STOP