Maryland
Foot & Ankle
Restoration, LLC

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: ____/____/____

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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_____

_____ _____

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