Atlanta Center for Reconstructive Foot & Ankle Surgery, LLC (Atlanta) Patient Waiver Policy & Agreement
(Provider Name)

In consideration of my particular medical needs and care expenses incurred solely based on such medical needs, and my financial ability to pay for such recommended medical services without or even with applicable insurance coverage, and with understanding that I am personally financially responsible for any and all medical charges regardless of any applicable insurance coverage, **I hereby declare that I have financial difficulty to pay for part or all expenses because of the following:**

☐ Insufficient current income
☐ Without any or applicable insurance for treatment at this medical provider
☐ With applicable insurance but still medically financially harmed (see below)

More importantly, I declare that without following payment assistance, seeking for and continuing with medically appropriate and important health care would have been impossible for me or would make me financially harmed if I were forced to pay full charges for my medically necessary care expenses after I have already paid the provider for my portion of the bills, but my insurance improperly denied my claims. I also declare that I personally requested for such payment assistance only after I was fully informed of my important medical treatment options and the necessity of said treatment options solely based on my particular medical needs and availability of this provider Payment Policy:

> *By* Payment Waiver *we mean a policy developed and utilized by a healthcare provider to determine patients' financial ability to pay for services. By "financially harmed," we mean patients whose health insurance coverage, if any, does not provide full coverage for all of their medical expenses and that their medical expenses, in relationship to their income, would make them financially harmed if they were forced to pay full charges for their medical expenses."*

While I request and designate my authorized representative to continue to submit any new claims/appeal any denied claims on my behalf, I specifically request under this payment waiver <u>for the following indigent discount assistance for the remaining total balance</u> on my account upon the exhaustion of the claims process**:**

Check all that you wish to be considered for:

☐ Waiving collection of deductible
☐ Waiving collection of co-pays/encounter fees
☐ Waiving collection of co-insurance
☐ Waiving collection of insurance denial: $_____

Patient's Signature _____ Date_____

Provider's Staff/Agent Signature _____ Date_____

ASSIGNMENT OF BENEFITS / ERISA AUTHORIZED REPRESENTATIVE FORM

Atlanta Center for Reconstructive Foot & Ankle Surgery, LLC

Financial Responsibility

I have requested professional services from Atlanta Center for Reconstructive Foot & Ankle Surgery, LLC ("Provider") on behalf of myself and/or my dependents, and understand that by making this request, I am responsible for all charges incurred during the course of said services. I understand that all fees for said services are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement unless other arrangements have been made in advance.

Assignment of Insurance Benefits

I hereby assign all applicable health insurance benefits to which I and/or my dependents are entitled to Provider. I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

I hereby authorize Provider to submit claims, on my and/or my dependent's behalf, to the benefit plan (or its administrator) listed on the current insurance card I provided to Provider, in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Provider directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to Provider, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and Provider upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make out the check to me and mail it directly to Provider.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

Authorization to Release Information

I hereby authorize Provider to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and(3) allow a photocopy of my signature to be used to process insurance claims I understand that any information disclosed pursuant to this authorization may be disclosed by the recipient pursuant to my providers Notice of Privacy disclosure and may not be protected by the federal privacy regulation. I understand that I have a right to revoke this authorization at any time by providing written notice to my Provider and my health benefit plan (or its administrator) via electronic mail, U.S. mail or facsimile. I further understand that there are no exceptions to my rights to revoke this authorization. Therefore, this authorization will remain in force and effect for claims with date of service within **one year** of the signature date, or until revoked by me in writing, or until my healthcare claims are adjudicated to my provider's satisfaction**.**

ERISA Authorization and Limited Power of Attorney

I hereby designate, authorize, and convey to CHRIS DUFFY and/or ALLIANCE MED, LLC, Provider's Third-Party Billing Service for the claims assigned hereunder, to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to sign any and all documents that require my signature, sent to or received from my health benefit plan (or its administrator) on my behalf, in the event that my health benefit plan (or its administrator) requires additional information; (2) the right and ability to act as my Authorized Representative in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan and assigned hereunder to Provider; and (3) the right and ability to act as my Authorized Representative to pursue any such claim, right, or cause of action in connection with said insurance policy and/or benefit plan including but not limited to, the right and ability to act as my Authorized Representative with respect to a benefit plan governed by the provisions of ERISA as provided in 29 *C.F.R.* §2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines;

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

_____ _____

Patient Date

_____ _____

Policyholder/ Insured Date

Date:_____

Benefits Election Letter

To whom it may concern:

This letter shall serve as notice that I am electing to engage my “Out of Network” medical benefits which may require an informed disclosure by my medical provider.

Since I have paid a higher premium for the ability to seek an “Out of Network” provider, I wish to have my provider compensated for any and all treatments/procedures which he/she believes to be medically necessary to treat my existing condition/ailment/injury.

Please be advised that benefits have been checked prior to receiving services, and if I do not receive an adverse benefit determination within 48 hours of the claims submission, I will assume all costs related to the treatment/procedure will be covered in their entirety as it states in my Summary of Benefits Coverage (SBC) documentation.

If an adverse benefit determination is received within 48 hours, please provide me with the entire claim file, including your copy of the SBC, that was utilized to make the determination so I can comply with the claims procedure process according the Patient Protection Affordable Care Act (PPACA) and the benefit plan in which I am enrolled.

Cordially,

_____

SUBMIT FORMS via Outlook