The Orthopaedic Center for
FOOT AND ANKLE RECONSTRUCTION

100 Kingsley Lane, Suite 300, Norfolk, Virginia 23505 Phone: 757-889-6580 Fax: 757-889-6583

I HEREBY CONSENT TO TREATMENT by the Physicians of The Orthopaedic Center for Foot and Ankle Reconstruction (OCFAR), their associates and/or assistants and accept responsibility for fees for such medical services. I understand that treatment may include x-rays, injections, medical appliances, and/or such other procedures as deemed necessary by the physicians at OCFAR.

I understand that the payment of copays at the time of service sis required by my insurance company and expected by OCFAR and that insurance is filed as a courtesy to me. I understand that I am financially responsible for charges not covered by my insurance. I further understand that if a balance exists on my account at the time of any litigation settlement relating to injuries for which I am being seen, my account with this practice will be the first bill paid and paid in full at the time of the settlement. **Should collection actions become necessary, I understand that I will be liable for any and all costs, including a fifty percent fee for placement with collections, interest at the rate of eighteen percent per annum from the date of treatment, and any attorney fees associated with collecting the unpaid balance owed on my account.**

I hereby authorize the release of any information necessary for filing of any insurance and authorize the assignment of all payments for medical services, for myself or my dependent, to the physicians of OCFAR. This authorization is valid for current and subsequent treatment unless I submit a written revocation. A copy of this authorization shall be considered as effective and valid as the original. I will advise OCFAR of any changes in insurance coverage. Failure to provide proper notice of insurance that result in denial for timely filing will result in my being responsible for the entire balance.

I also authorize OCFAR to speak with and exchange information with other medical professionals regarding my medical condition and treatment. These medical professionals may include, but are not limited to: physical therapists, occupational therapists, athletic trainers, nurses, physician's assistants, rehabilitation specialists, case workers, primary care physicians, referring physicians, and nurse practioners.

I understand that as a condition of my treatment at OCFAR, in the event litigation is required in this case, neither the physician nor the office staff will be available to appear in court. Conferences and/or depositions are scheduled.

If health care workers are accidentally exposed to my blood or body fluids in the course of providing health care to me, I agree to have my blood tested for any infectious disease which might be transmitted to them through this exposure, including HIV/AIDS and hepatitis.

I agree to pay a fee of $25.00 for any check that is returned to the practice for insufficient funds.

I agree that I may be charged and I will pay a $50 fee for any appointment I do not keep without at least 24 hours notice of cancellation.

Signed:_____ _____ _____

Patient or Responsible Party Date Witness