

**FAMILY ORTHOPAEDICS & SPORTS MEDICINE
OF NORTHERN VIRGINIA**

Kenneth G. Ward, M.D.
Wylie D. Lowery Jr., M.D.
Mark J. Scheer, M.D.

PATIENT RESPONSIBILITIES

ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION AUTHORIZATION

I, the undersigned, hereby authorize Kenneth G. Ward, M.D., Wylie D. Lowery, M.D., and Mark J. Scheer, M.D. to release any and all medical information to the insurance carrier, attorney, or workers compensation **for purposes of claims administration and evaluation, utilization review and financial audit.** This authorization remains valid and effective from the date of signing until revoked in writing. I hereby assign to Kenneth G. Ward, M.D., Wylie D. Lowery, M.D., and Mark J. Scheer, M.D. all money to which I am entitled for medical and/or surgical expenses relative to the services rendered by them. I understand and agree that I am financially responsible for co-payments, deductibles, and non-covered charges, as per my insurance company, to be paid to Kenneth G. Ward, M.D., Wylie D. Lowery, M.D., and Mark J. Scheer, M.D. within thirty days of the initial patient billing. Should payment arrangements become necessary, please call the billing office at (703) 690-4992. I also agree to pay reasonable attorney fees should it become necessary for the filing of a civil suit to collect said bills.

SIGNIFICANT EXPOSURE

Section 32.1-45 (A) and (B), Code of Virginia (1950, as amended) provides that in the event of significant exposure (e.g. needle stick), consent for testing for Human Immunodeficiency Virus (HIV), Hepatitis B Virus and Hepatitis C Virus is considered to have been given by the patient and/or healthcare worker thereby granting Kenneth G. Ward, M.D., Wylie D. Lowery, M.D., and Mark J. Scheer, M.D. the right to perform such tests. Test results are considered confidential and can only be released in accordance with applicable laws.

REFERRALS, AUTHORIZATIONS, COPAYS AND APPOINTMENTS

I, the undersigned understand that, should my insurance company/policy require a referral or authorization from my primary care physician in order for me to receive treatment from a specialist such as Kenneth G. Ward, M.D., Wylie D. Lowery, M.D., and Mark J. Scheer, M.D., **it is my responsibility to obtain the referral including authorization for x-rays prior to my office visit.** I further understand that should I fail to bring a referral and authorization for x-rays with me to my appointment, **my appointment may be rescheduled.** I also understand it is my responsibility to know the number of visits allowed and the expiration date of my referral. Co-payment must be paid at the time services are rendered. All appointments should be scheduled in advance and whenever possible 24 hours should be given for cancellations.

PRESCRIPTIONS AND REFILLS

Prescriptions and refills are issued **Monday through Thursday 9:00 a.m. through 5:00 p.m. only**, by telephoning (703) 690 – 1152. On evenings and weekends, your patient record is not readily available. **Anticipate your needs and do not wait until you are out of your medication to call.** Should you experience any side effects to your medication, please stop promptly and call us.

WORKERS COMPENSATION

If you are being seen for a work related injury, we must have approval from your employer prior to your appointment. However the responsibility for payment rest with you the patient.

BILLING PROCEDURES

This office bills your primary insurance company as a courtesy. Even though you have insurance coverage, this account is your personal responsibility. I, the undersigned, agree to pay a fee of \$25.00 for any check returned by my financial institution regardless of reason. Please Note: In order to reduce billing cost and allow us to continue to participate with your insurance plan, we are asking that you provide a credit card number. Making your credit card information available to the accounting department will reduce the risk of your account going to collections. Your credit card would only be billed after the insurance company has made payment and the appropriate adjustments have been applied to your account.

I _____ authorize Family Orthopaedics to bill my credit card after the
Signature
insurance company has made payment and the appropriate adjustments have been applied to my account.

Credit Card: Visa or Master Card Acct# _____ Expiration Date: _____

I understand that I may request a copy of this agreement at any time.

I have read and understand the above: _____
Signature *Date*