WAFL, Inc./Brock A Liden D.P.M.

BILLING AUTHORIZATION AND CONSENT TO TREAT

1. CONSENT TO MEDICAL AND SURGICAL PROCEDURES The undersigned consents to the medical and surgical care and treatment, as may be deemed necessary or advisable in the judgment of my physician or other provider, which may include but are not limited to laboratory procedures, x-ray examination, medical or surgical treatment or procedures, anesthesia, or other services rendered the patient under the general and special instructions of the patient's physician.

If I request or initiate a telehealth visit (a "virtual visit'), I hereby consent to participate in such telehealth visit and its recording and I understand I may terminate such visit at any time.

2. ASSIGNMENT OF INSURANCE BENEFITS and AUTHORIZATION TO RELEASE INFORMATION In consideration of services rendered, I hereby transfer and assign to WAFL, Inc./Brock A Liden DPM (herein referred to as the practice) all rights, title and interest in any payment due to me for services described herein as provided in the above-mentioned policy or policies of insurance. The practice may disclose all or any part of the patient's record (including psychiatric, alcohol and drug abuse, family member or employer of the patient) for all or part of the practices charge, including but not limited to medical service companies, insurance companies, workers compensation carriers, welfare funds or the patient's employer. I further authorize physicians to access my medical prescription history via the Ohio Automated Rx Reporting System (OARRS), or current medications via Surescripts if deemed necessary, for my treatment.

3. FINANCIAL AGREEMENT The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she obligates himself/herself to pay the account of the practice in accordance with the regular rates and terms of the practice. Should the account be referred to an attorney for collections, the undersigned should pay reasonable attorney's fees and collection expenses. The undersigned certifies that he/she has read the foregoing, receiving a copy thereof if requested, and is the patient or is duly authorized by the patient as patient's general agent to execute the above and accepts its terms.

4. MEDICARE/MEDICAID Patient's certification authorization to release information and payment request. I certify that the information given to me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize that any holder of medical or other information about me may release to Social Security Administration/Division of Family Services or its intermediaries or carries any information needed for this or a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the practice treating me.

5. USE OF COPIES I permit a copy of these authorizations and assignments to be used in place of the original, which is on file at the practice.

6. CONSENT TO CALL, EMAIL & TEXT I understand and agree that my provider may contact me using automated calls, emails and/or text messaging sent to my landline and/or mobile device. These communications may notify me of preventative care, test results, treatment recommendations, outstanding balances, or any other communications from my provider. I understand that I may opt-out of receiving all such communications from my provider by notifying my provider's staff, by visiting "My Profile" on my myPrivia Patient Portal, or by emailing the Privacy Officer at privacy@priviahealth.com.

7. PAYMENT RESPONSIBILITY I understand that certain insurance claims may be filed as a courtesy. However, if a claim is denied for any reason, I am responsible for payment. Insurance is considered a method of reimbursing the physician for services rendered to the patient. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charges. I understand it is my responsibility to pay any CO-PAY, DEDUCTIBLE, CO-INSURANCE, OR ANY OTHER BALANCE NOT PAID FOR BY MY INSURANCE OR THIRD-PARTY PAYOR WITHIN A REASONABLE PERIOD OF TIME NOT TO EXCEED 60 DAYS.

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGMENT

I have been given access to the Summary of Notice of Privacy Practices on this or a prior occasion on my provider's website and at priviahealth.com/hipaa-privacy-notice/ and acknowledge that I have been given a copy, if requested.

I hereby acknowledge that I have received my provider's Financial Policy as well as my provider's Notice of Privacy Practices. I agree to the terms of my provider's Financial Policy, the sharing of my information via HIE,* and consent to my treatment by my provider. This form and my assignment of benefits applies and extends to subsequent visits and appointments with all Privia Health affiliated providers.

Printed Name of Patient: _____ **Email:** _____

Signature: _____ **Date:** _____

To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent.

Name and Relationship of Person Signing, if not Patient: _____

*Note: If you do not want to participate in Health Information Exchange (HIE), it is <u>your</u> responsibility to follow the instructions outlined on the my provider HIE Opt-Out Request Form and/or contact HIE directly.