ACKNOWLEDGEMENT OF OUR NOTICE OF PRIVACY PRACTICES

POLICY REGARDING PHOTOGRAPHY, AUDIO AND/OR VIDEO RECORDING

Patients, family members of patients, and/or visitors Regional Orthopaedic Associates are not permitted to make audio recordings, make video recordings, or take photographs (using a cellular or "smart" phone, or by other electronic means) in any examination or clinical areas of the practice without the prior express written consent of Regional Orthopaedic Associates.

This policy prohibits, by way of example and without limitation, the recording of any conversations between patients, family members of patients, and/or visitors and Regional Orthopaedic Associates physicians or staff, as well as the recording or photographing of any of the practice's communication boards, portions of medical records, patient labels on medical record binders, and any other such items or materials bearing patient names and/or any other identifying information.

To the extent Regional Orthopaedic Associates is made aware of any inappropriate attempt to violate this policy, Regional Orthopaedic Associates will take reasonable measures to require that prohibited recording or photographing be stopped immediately at any time.

Regional Orthopaedic Associates

1941 Limestone Road, Suite 101
Wimington, DE 19808

1096 Old Churchmans Road
Newark, DE 19713

3401 Brandywine Parkway, Suite 100 & 101
Wilmington, DE 19803

252 Carter Drive, Suite 101
Middletown, DE 19709

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Regional Orthopaedic Associates Notice of Privacy Practices. By signing below I am "only" giving acknowledgement that I have received or had the opportunity to receive the Notice of Privacy Practices.

_____ _____

Patient Name (Type or Print) Date

_____

Signature

AUTHORIZATION TO RELEASE INFORMATION

I, _____, give permission to Regional Orthopaedic Associates (ROA) to disclose the following information from my health records. Any information listed below that I have crossed out may not be released. I give consent for the following information to be released:

1. Complete Health Record
2. History and Physical Examinations
3. Consultation Reports
4. X-Ray Reports
5. Discharge Summary
6. Progress Notes
7. Laboratory Results
8. Photos or Other Images

I understand this may include personal information relating to AIDS, HIV INFECTION or HEPATITIS INFECTION.

The above information may be disclosed to or received by:

AMBULATORY SURGICAL CENTERS
ATTORNEY (PATIENT AND ROA)
HOSPITAL (ADMISSION)
MALPRACTICE CARRIER
MEDICARE / HEALTH INSURANCE COMPANIES (CLAIMS ISSUES)
OTHER CARE GIVERS (REFERRALS FOR ADDED CARE)

I also give consent for messages from ROA & facilities that ROA uses to be released to:

___ Left on home phone answering machine Phone Number _____
___ Work Voice Mail Phone Number _____
___ Spouse Name of Spouse _____
___ Child Name of Child _____
___ Other Name and Relationship _____

I prefer to be contacted at:
___ Work Phone Number _____
___ Home Phone Number _____
___ Other Phone Number _____

I understand that this consent will remain a permanent part of my medical record and that does not expire. I also understand that I may, at any time, revoke this consent, or any part thereof, in writing. I understand that ROA will do all in their power to see that any personal information is maintained in a professional manner and only released to those that it deems appropriate to receive said information. I also understand that ROA is required by Law to maintain the privacy of, and provide individuals with, this notice of their legal duties and privacy practices with respect to PHI. If you have any objections to this form, please ask to speak to our HIPAA Compliance Officer in person or by phone at (302) 655-9494. My signature on this form acknowledges my completion of the above information and that I received a copy of ROA's Notice of Privacy Practices.

Print Name: _____

Signature: _____ Date: _____

Signature of Staff Member: _____ Date: _____

Regional Orthopaedic Associates
Patient Payment Policy

Regional Orthopaedic Associates is committed to provide you with the best care possible. We will, where applicable, file a claim with your medical insurance carrier on your behalf. Monies paid to Regional Orthopaedic Associates will be appropriately applied to your account with our office. Balances remaining after payment is received from your insurance carrier will be billed to the patient/guarantor. Like most physicians' offices, we require full payment at time of service. For your convenience we accept; personal checks, cash, Visa, Mastercard and Discover.

Participating Plans
Regional Orthopaedic Associates is a participating provider with several health insurance plans. Amongst them are:

Aetna – US Healthcare	Independence Blue Cross
Amerihealth	Medicare
Blue Cross and Blue Shield of Delaware	Tricare
Coventry	United Health Care

Please check your individual policy to verify that we are listed as a participating provider. For those patients' insurance companies with whom we are a participating provider, we will submit your claim for you. However, all deductibles, co-insurances and co-payments are due at time of service.

Referrals and Pre-authorizations
If your insurance policy requires you to have a referral or a pre-authorization from your primary care physician prior to treatment in our office, it is *your* responsibility to ensure that it has been received in our office. If we do not have your required referral or pre-authorization, it will be necessary to reschedule your appointment to a time when those requirements have been met.

Non-participating Plans
As a courtesy, Regional Orthopaedic Associates will submit your claim for you. However, any fees not covered by your insurance will be billed to the patient's guarantor.

Alternative Payment Arrangements
Regional Orthopaedic Associates recognizes that medical expenses are sometimes unplanned and may be incurred during a period of financial hardship. In the event of financial hardship, our Billing Associates are equipped to assist you. Dependent upon the needs of the patient, a prompt pay discount may be made available, or in certain circumstances, a payment plan can be made available. However, such arrangements must be made prior to receiving treatment.

Injury Claims
Regional Orthopaedic Associates will file the claims for patients with Workers' Compensation, automobile or personal injury insurances. The patient with this type of applicable coverage must provide us with the following:

Name of insurance carrier	Claim or case number
Mailing address for claims	Adjuster's name
Date of loss, injury or accident	Adjuster's telephone number

Additionally, you must provide us with your personal medical insurance information. This will enable us to file a health claim should payment from your injury claim be exhausted or denied. If for any reason you do not provide us with your personal medical insurance information, you will be responsible for all balances should your injury claim be exhausted or denied.

Bad Check or NSF Policy
In the event of a Bad or NSF check, you will incur a fee of $25.00 in addition to the balance when a check is returned unpaid. If the obligation is not satisfied within ten (10) days of the NSF notification, the check will be forwarded to the State of Delaware office of the Attorney General.

Missed and No Show Appointments
Missed and cancelled appointments with insufficient notice (24 hours) impact our ability to deliver care to our patients. When a patient misses an office appointment, a Missed Office Appointment fee of $25.00 will be charged to the responsible party. When an EPAT, MRI, EMG or Concussion Test appointment is missed or cancelled, there will be a $50 fee charged. When a surgical appointment is missed or cancelled with less than twenty-four hours notice a Missed Surgery Fee of $250.00 of the surgical fee may be charged to the responsible party. The application of these fees is solely at the discretion of the physician. In the event of an unforeseen and valid reason the fee may be waived. Examples of such unforeseen and valid reasons are family emergencies, a vehicle accident, and illness.

Collection Accounts
Patient accounts that have been referred to a collection agency for lack of payment are subject to a $25.00 handling fee and up to a 50% surcharge. Once accounts are referred to a collection agency, patients/guarantors must communicate directly with the agency to resolve account balances.

Form Completion
The completion of forms will be subject to a $30 fee for each form completed. Payment is expected before the completion of the forms. Paperwork will be completed within 7-10 business days.

Patient Signature _____ Date _____