

Washington Orthopaedic and Knee Clinic, Inc.

WASHINGTON ORTHOPAEDIC & KNEE CLINIC GENERAL POLICIES

M. M. Malek, M.D., F.A.C.S.
Director

Diplomate,
American Board of
Orthopaedic Surgery

Fellow, American Academy
of Orthopaedic Surgeons

Member, American
Orthopaedic Association

Fellow, American College
of Surgeons

Member, Arthroscopy
Association of North America

Member, American
Orthopaedic Society for
Sports Medicine

Member, American
Association of Hip and
Knee Surgeons

Member, International
Society of Arthroscopy, Knee
Surgery and Orthopaedic
Sports Medicine

Member, Osteoarthritis
Research Society International

8316 Arlington Blvd.
#510
Fairfax, Va. 22031
Tel: 703-641-5633
Fax: 703-289-1273

Please address all
correspondence to:

P.O. Box 10626
McLean, VA 22102-9626

Website:
www.kneeman.com

It is the policy of this office to verify insurance coverage for the services rendered at our facility, out of courtesy to our patients, before time of office visit.

THIS VERIFICATION OF COVERAGE IS NOT A GUARANTEE OF PAYMENT OR ELIGIBILITY.

This verification has been done out of courtesy, but it is you, the patient, who has the responsibility to confirm your coverage, to verify your policy waiting period and pre-existing condition, to confirm that your insurance will accept us as a "participating provider" and to obtain if necessary the appropriate referral required by your insurance policy.

WASHINGTON ORTHOPAEDIC & KNEE CLINIC, INC., REQUIRES CO-PAYS AND CO-INSURANCE (INCLUDING ANY DEDUCTIBLE NOT MET) BE PAID BEFORE TIME OF SERVICE. IF YOU ARE UNABLE TO PROVIDE YOUR PAYMENTS, WE WILL GLADLY RESCHEDULE YOUR APPOINTMENT FOR THE NEXT AVAILABLE DATE. WE ONLY ACCEPT CASH OR CHECKS (NO CREDIT CARDS) AS A FORM OF PAYMENT, NO EXCEPTIONS. IF POSSIBLE, BRING EXACT PAYMENT OR AT LEAST, NO LARGE BILLS.

THIS OFFICE DOES NOT ACCEPT LARGE AMOUNTS OF COINS AS PAYMENT.

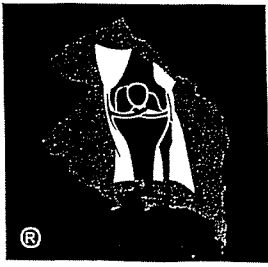
THOUGH OUR OFFICE STAFF IS WILLING TO WORK WITH YOU, YOU ARE ULTIMATELY RESPONSIBLE FOR YOUR BILL UNTIL IT IS PAID IN FULL.

A FEE OF \$35.00 WILL BE CHARGED FOR ANY RETURNED CHECKS.

WE WILL CHARGE 15% PER ANNUM ON ANY BALANCE OVER 30 DAYS.

ALSO, ANY COST INCURRED (MINIMUM 30%) IN CONNECTION WITH THE COLLECTION OF THE BALANCE DUE SUCH AS ATTORNEY FEES, COLLECTION AGENCY FEES AND/OR COURT COST, TO SATISFY OUTSTANDING BALANCES ARE THE PATIENT'S RESPONSIBILITY AND WILL BE COLLECTED.

A FEE OF \$50.00 WILL ALSO BE CHARGED FOR ANY DOCTOR'S APPOINTMENTS THAT ARE NOT CANCELED WITHOUT A 24 HOURS NOTICE.



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DUE TO ADMINISTRATIVE COST AND TIME, WE WILL NO LONGER FAX PRESCRIPTIONS OR DISABILITY SLIPS THAT HAVE BEEN MISPLACED, LOST OR FORGOTTEN. IF YOU INSIST, THEN YOU MUST PROVIDE US WITH A CREDIT CARD NUMBER AND A \$15.00 ADMINISTRATIVE FEE WILL BE CHARGED TO YOUR CREDIT CARD BEFORE THE PRESCRIPTION IS FAXED.

THESE ARE ADDITIONAL EXPENSES THAT ARE NOT COVERED BY YOUR INSURANCE AND THEREFORE MUST BE PAST ON TO YOU, THE PATIENT.

THERE IS ALSO A CHARGE FOR ALL FORMS INCLUDING DISABILITY, DMV AND OTHERS, AS WELL AS LETTERS DONE BY THE DOCTOR, COPIES OF MEDIAL RECORDS, ETC. PLEASE CHECK WITH THE STAFF REGARDING THESE FEES. (CASH ONLY).

If you belong to an HMO and you wish your claims to be processed in-network, you understand that it is your responsibility to provide this office with a PROPERLY DATED AND VALID REFERRAL FROM YOUR PRIMARY CARE PHYSICIAN. You understand further that you are financially responsible for any visits for which you do not provide a valid referral. You also understand that you are financially responsible for any services which are not covered under your health care plan.

You acknowledge that you chose Washington Orthopaedic and Knee Clinic to seek treatment. You understand if neither Washington Orthopaedic and Knee Clinic nor its physician participate in your HMO/PPO Benefit Plan you are solely responsible for all charges incurred and that your benefit plan will not pay the provider, that the provider will not accept payment from the plan, that your obligation to pay your plan's premiums will not be affected.

Patient medical records shall be maintain for a minimum of six years following the patient's last encounter with the physician.

I have read the above information and understand the contents completely.

Patient's Name, Please Print

Signature of Patient or Guardian if under 18

Date

Witness

Amended 3/18/15

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