

FAIRFAX COLON & RECTAL SURGERY, P.C.
FAIRFAX COLON & RECTAL SURGICAL CENTER, L.L.C.

DONALD B. COLVIN, MD, FASCRS
PAUL E. SAVOCA, MD, FASCRS
LYNDA S. DOUGHERTY, MD, FASCRS
DANIEL P. OTCHY, MD, FASCRS
LAWRENCE E. STERN, MD, FASCRS
KIMBERLY A. MATZIE, MD
ELIZABETH YORK, PA-C
COLORECTAL/ANORECTAL SURGERY, COLONOSCOPY, ANORECTAL PHYSIOLOGY

SURGICAL CENTER POLICIES

The Healthcare Industry is experiencing a dramatic increase in the cost of malpractice insurance in the state of Virginia. At the same time, reimbursement from insurance companies continues to decline. We now find it necessary to institute several changes in our surgical center policies. We appreciate your cooperation and understanding while we endeavor to provide you with the best possible medical care. For your convenience, we accept cash, checks, money orders, debit and most credit cards.

DISCLOSURE OF OWNERSHIP: I have been advised of the following:

A physician performing a procedure in our surgical center may have an ownership interest in this facility. Currently, the following physicians have an ownership interest in the facility: Dr. Donald Colvin, Dr. Paul Savoca, Dr. Lynda Dougherty, Dr. Daniel Otchy, Dr. Lawrence Stern.

A schedule of typical fees for services provided by this facility is available upon request. These procedures are performed at hospitals and other outpatient facilities in this community. I have the right to choose where to receive services, including a facility where my physician does or does not have an ownership interest. I have chosen to be treated at this facility.

ARRIVAL TIME AND PAPERWORK: Unless you are otherwise informed, please arrive 60 minutes before your scheduled procedure in order to complete the admission process. This will help us to keep to the scheduled surgery times. Updating paperwork is required for every visit to the office. In addition, for each visit you will need to have your insurance card and a government issued photo id. If not already completed in advance of your office visit, registration paperwork can be found on our website on the Registration & Policy Forms link, and submitted in advance of your appointment to speed your check in process.

MISSED APPOINTMENTS: Missed procedures/surgical appointments are appointment cancelled with less than a 7 day notice and will incur a \$200.00 charge. Abusive missed procedures may result in your dismissal as a patient.

RESCHEDULING: Because we are a surgical practice, emergency situations may arise that result in the physician being called away to the operating room. If the physician is unable to perform your procedure as a result of the emergency, he or she may request that another physician in this practice perform your procedure. If you wish to reschedule, every effort will be made to accommodate you. During these times we appreciate your patience and understanding.

MEDICAL RECORDS: To obtain copies of your medical records you must sign a Medical Release form. There is a \$10.00 processing fee, plus \$0.50/page. These fees, set forth by Virginia State law, must be paid in full before your request can be processed. Please allow up to two weeks for processing.

FORMS, LETTERS, REPORTS: Disability, workman's compensation, etc... The fee for completion of these items is \$35.00. All fees must be paid in full before the forms can be produced. Please allow at least one week for processing.

YOUR RIDE HOME: You will need a ride to take you to and from our Center for your procedure. You will not be taken back for your procedure until the nurse has confirmed that your driver is in our waiting area. If your ride is not available when you are ready to be discharged a \$100 administrative fee will be assessed.

PRESCRIPTIONS: If for any reason your prescription for medication, CT Scan, MRI, PET scan, etc., needs to be rewritten there will be a \$10.00 charge for a replacement to be called or faxed to a pharmacy or radiologist, or mailed to you. Please utilize our website www.fairfaxcolorectal.com for prescription refills.

FINANCIAL RESPONSIBILITY: If you are having a procedure in our surgical center, you may receive bills from several different providers: the physician performing the procedure, the Ambulatory Surgical Center, Anesthesia providers, and a laboratory if specimens are obtained during your procedure. Please note, because the insurance policy is an agreement between the insured and the insurance company, we expect all patients or their guardian to be fully responsible for knowledge of your insurance benefits, as well as fully and directly responsible for all charges regardless of insurance coverage. Please be assured that we will do everything possible to see that you receive your full benefits in a timely manner. **If your insurance company has not paid their portion of your bill within 60 days, you will be responsible for full payment at that time.**

OUTSTANDING BILLS AND COLLECTIONS: I understand that there will be a 5% late fee for balances not paid when due (within 30 days of the first statement date) unless other arrangements have been made. In addition, in the event my account becomes past due (over 30 days) and arrangements for payment have not been made, my account may be placed for collection. I also understand that I will be responsible for all costs of collection including agency fees, court cost and/or attorney fees.

PARTICIPATING INSURANCE: COPAY, DEDUCTIBLE AND COINSURANCE: Where we have a participating agreement with your insurance company, we will expect your estimated co-payment and/or co-insurance at the time of treatment. We may also request that you pay any outstanding deductible. Contracts with insurance companies do not permit the waiver of these fees under any circumstances.

NON PARTICIPATING INSURANCE: We will file with your insurance company as a courtesy. However, you will be responsible for all charges not covered by insurance.

NO INSURANCE: Payment in full is due at the time of treatment. When necessary, payment plans may be arranged with our billing director.

RETURNED CHECK FEE: \$35.00 for each check returned for insufficient funds or closed account.

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OFFICE VISIT POLICIES

The Healthcare Industry is experiencing a dramatic increase in the cost of malpractice insurance in the state of Virginia. At the same time, reimbursement from insurance companies continues to decline. We now find it necessary to institute several changes to our office policies. We appreciate your cooperation and understanding while we endeavor to provide you with the best possible medical care. For your convenience, we accept cash, checks, money orders, debit and most credit cards.

ARRIVAL TIME AND PAPERWORK: Please arrive 15 minutes before your scheduled appointment time in order to complete the paperwork necessary for your visit. This will help us to keep to the scheduled appointment times. Updating paperwork is required for every visit to the office. In addition, for each visit you will need to have your insurance card and a government issued photo id. Registration paperwork can be found on our website on the Registration & Policy Forms link, and submitted in advance of your appointment to speed your check in process.

MISSED APPOINTMENTS: Missed office appointments are appointments cancelled with less than 24 hours notice and will incur a \$50 charge. Missed ARPS appointments cancelled with less than 24 hours notice will incur a \$100 charge. Missed procedures/surgical appointments with less than a 7 day notice of cancellation will incur a \$200.00 charge. Abusive missed appointments may result in your dismissal as a patient.

RESCHEDULING: Because we are a surgical practice, emergency situations may arise that result in the physician being called away to the operating room. As a result, your appointment may need to be rescheduled or the physician may run late. During these times we appreciate your patience and understanding.

MEDICAL RECORDS: To obtain copies of your medical records you must sign a Medical Release form. There is a \$10.00 processing fee, plus \$0.50/page. These fees, set forth by Virginia State law, must be paid in full before your request can be processed. Please allow up to two weeks for processing.

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PRESCRIPTIONS: If for any reason your prescription for medication, CT Scan, MRI, PET scan, etc., needs to be rewritten there will be a \$10.00 charge for a replacement to be called in or faxed to a pharmacy or radiologist, or mailed to you. Please utilize our website www.fairfaxcolorectal.com for prescription refills.

FINANCIAL RESPONSIBILITY: Please note, because the insurance policy is an agreement between the insured and the insurance company, we expect all patients or their guardian to be fully responsible for knowledge of your insurance benefits, as well as fully and directly responsible for all charges regardless of insurance coverage. Please be assured that we will do everything possible to see that you receive your full benefits in a timely manner. **If your insurance company has not paid their portion of your bill within 60 days, you will be responsible for full payment at that time.**

OUTSTANDING BILLS AND COLLECTIONS: I understand that there will be a 5% late fee for balances not paid when due (within 30 days of the first statement date) unless other arrangements have been made. In addition, in the event my account becomes past due (over 30 days) and arrangements for payment have not been made, my account may be placed for collection. I also understand that I will be responsible for all costs of collection including agency fees, court cost and/or attorney fees.

PARTICIPATING INSURANCE: COPAY, DEDUCTIBLE AND COINSURANCE: Where we have a participating agreement with your insurance company, we will expect your estimated co-payment and/or co-insurance at the time of treatment. We may also request that you pay any outstanding deductible. Contracts with insurance companies do not permit the waiver of these fees under any circumstances.

NON PARTICIPATING INSURANCE: We will file with your insurance company as a courtesy. However, you will be responsible for all charges not covered by insurance.

NO INSURANCE: Payment in full is due at the time of treatment. When necessary, payment plans may be arranged with our billing director.

UNANTICIPATED LAB TESTS: In the unlikely event that an occurrence in the office that is not in furtherance of your exam, procedure or treatment requires that we submit blood samples to a lab for testing, we will submit the charges for such testing to your insurance carrier for payment but will not hold you responsible for any amounts not covered.

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PRIVACY FORM (HIPPA)

This notice describes how medical information about you may be used and disclosed and how you can get access to this Information. Please review it carefully. You may ask for a copy of this notice at any time, and a copy is available on the web at www.fairfaxcolorectal.com.

Patient Health Information: Under federal law, your patient health information is protected and confidential. This information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information includes payment, billing, and insurance information.

How we use your Health Information: We use health information about you for treatment, to obtain payment, and for healthcare operations including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances we may be required to use or disclose the information without your permission.

Examples of Care, Payment, and Healthcare Operations: Treatment—We will use and disclose your health information to provide your medical treatment. For example, nurses, physicians, and other members of your treatment team will record and use it to determine your care. We may also disclose information to other healthcare providers who are helping in your treatment, to pharmacists filling your prescriptions, and to family members helping with your care. **Payment**—We will disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain your records of payment. **Health Care Operations**—We will use and disclose your health information to conduct our standard internal operations, including the administration of records, the evaluation of the quality of treatment, and the assessment of outcomes. **Special use:** We may use your information to contact you with appointment reminders. We may also contact you to provide information about different treatment options.

Other Uses and Disclosures: We may use or disclose health information about you for other purposes. Subject to certain requirements, we are permitted disclosure for the following purposes: **Required by Law**—We may be required by law to report gunshot wounds, suspected abuse, suspected neglect, or similar events. **Research**—We may use or disclose information for approved medical research. **Public Health Activities**—As required by law, we may disclose vital statistics, disease, information related to recalls of products, and similar information to health authorities. **Health Oversight**—We may disclose information to assist in investigation and audits, and eligibility for government programs. **Judicial Proceedings**—We will disclose information in response to subpoena or court order. **Law Enforcement Purposes**—We may disclose information subject to certain restrictions. **Workers' Compensation**—We may release information about your workers' compensation or other programs providing benefits for work-related injuries or illness. **Military or Special Government Functions**—If a member of the armed forces, we will release information as military authorities or correctional facilities command, or for national security. **Death**—We must report information regarding deaths to the coroner, medical examiner, funeral directors, and organ donation programs. **Serious Threat to Health and Safety**—We may share information when needed to prevent a serious threat to your health, safety, and/or to the public.

Individual Rights: You have the following rights with your health information. **Request Restrictions**—You may request restrictions on some uses of this information, although we are not required to agree with this request. **Confidential Communications**—You may request that we communicate with only you. You may request a special address or phone number. **Inspect and Obtain Copies**—In most cases you have the right to look and receive a copy of your information. **Amend Information**—If you believe there are errors in your information, or information is missing, you may request that it be modified. **Accounting of Disclosure**—You may request a history of the disclosure of the information about you for reasons OTHER than treatment, payment, or operations.

Our Legal Requirement: We are required to provide you with this notice, to protect your information, and to abide by the terms of this notice.

Changes in a Privacy Practice: We may change these terms at any time. We will change our notice to reflect the terms that we change. We will also post the terms changes in our waiting room. You may request a copy of this notice and/or the changes at any time. You may contact us to answer any questions.

Release of Information: I authorize the facility to release all or part of my medical records when required for the submission of any insurance claims for payment to the Centers for Medicare and Medicaid Services and their agents, my insurance company(s), or to my employer (if this is a workers compensation claim).

I also authorize reports of my evaluation, treatments, and any follow up evaluations to be sent to or discussed with my referring Doctor, the Doctor requesting the consultation, my family Physician(s), as well as any other healthcare providers, hospitals, or outpatient facilities that I have or will identify to you. I permit a copy/fax of this form to serve as an original signature of authorization.

Complaints: If you have a complaint that may reveal we have violated this privacy statement, or do not agree with a decision that we made in regard to your information, please contact us. You may also contact the US Department of Health and Human Services. We will provide you with the correct address upon request.

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PATIENT BILL OF RIGHTS AND RESPONSIBILITIES

RIGHTS

1. The right to considerate and respectful care, in a safe environment, free from all forms of abuse or harassment. The patient may exercise these rights without regard to sex or cultural, economic, educational or religious background or the source of payment for care.
2. The right to full privacy concerning my medical care program. Case discussion, consultation, examination and treatment are confidential and should be conducted discretely. The patient has the right to be advised as to the reason for the presence of any individual involved in his or her healthcare.
3. The right to confidential treatment of all communications and records pertaining to his or her care and his or her visit at the facility. Except when required by law, patients are given the opportunity to approve or refuse their release. The patient also has the right to access information contained in his or her medical record within a reasonable time frame (within 48 hours of request, excluding weekends and holidays).
4. The right to be informed of my rights as a patient in advance of, or when discontinuing care. I may appoint a representative to receive this information should I so desire, and all my patient's rights apply to this person.
5. The right to know the names of the physician who has primary responsibility for coordinating his or her care and the names and professional relationships of other physicians and healthcare providers who will see him or her. The patient has the right to change the primary physician if another is available. The patient also has the right to know the credentialing process for medical staff.
6. The right to receive information from his or her physician about the illness, his or her course of treatment (including unanticipated outcomes), and prospects for recovery in terms that he or she can understand.
7. The right to receive as much information about any proposed treatment or procedure as he or she may need in order to give informed consent or to refuse the course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in the treatment, alternate course of treatment or non-treatment and the risks involved in each and to know the name of the person who will carry out the procedure or treatment.
8. The right to, upon request and prior to the initiation of care or treatment, get an estimate of the facility charges, potential insurance payments and an estimate of any co-payment, deductible, or other charges that will not be paid by insurance.
9. The right to participate in the development and implementation of his or her plan of care and actively participate in decisions regarding his or her medical care. To the extent permitted by law, this includes the right to request and/or refuse treatment.
10. The right to be given a copy of the patient rights when admitted to the facility.
11. The right to services provided at the facility and reasonable responses to any reasonable request he or she may make for service.
12. The right to be informed that the facility is not for emergency care. Therefore all after hours' care will be directed to the closest emergency room.
13. The right to examine and receive the fees for service, the explanation of his or her bill, and the payment policy regardless of source of payment.
14. The right to refuse to participate in experimental research.
15. The right to be advised of the policy on advance directives, and living wills in the facility and to be given information upon request.
16. The right to be seen at a facility in which all physicians will carry malpractice insurance.

17. The right to redress a grievance and to be advised of the facility's grievance process should the patient wish to communicate a concern regarding the quality of the care received, or if the patient feels determined discharge date is premature.

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18. The right to appropriate assessment and management of pain.
19. The right to remain free from seclusion or restraints of any form that are not medically necessary or are used as a means of coercion, discipline, convenience, or retaliation by staff.
20. The right to have a family member or representative of the patient's choice notified promptly of his or her admission to the facility, and the right to have his or her personal physician notified promptly of the patient's admission to the facility.
21. The right to leave the facility even against the advice of his or her physician and to know which facility rules and policies apply to his or her conduct while a patient.

RESPONSIBILITIES

22. The patient has the responsibility to provide accurate and complete information concerning his/her present complaints, past illnesses and hospitalizations, and other matters relating to his/her health.
23. The patient is responsible for reporting perceived risks in his/her care and unexpected changes in condition to his/her responsible practitioner.
24. The patient and family are responsible for asking questions when they do not understand what they have been told about the patient's care or what they are expected to do.
25. The patient is responsible for following the treatment plan established by his or her physician, including the instructions of nurses and other health professionals as they carry out the physician's orders.
26. The patient is responsible for keeping appointments and for notifying the facility or physician when he or she is unable to do so.
27. The patient is responsible for his or her actions should he or she refuse treatment or not follow his or her physician's orders.
28. The patient is responsible for assuring that the financial obligations of his or her care are fulfilled as promptly as possible.
29. The patient is responsible for following facility policies and procedures.
30. The patient is responsible for being considerate of the rights of other patients and facility personnel.
31. The patient is responsible for being respectful of his or her personal property and that of other persons in the facility.

ADVANCE DIRECTIVES

Federal Law directs that any time you are admitted to a health care facility, you must be told about laws concerning your right to make health care decisions. This applies to all patients, no matter what their medical condition. You have the right to consent or refuse any medical care and treatment, unless care is ordered by a court.

In an emergency, your consent to resuscitation (CPR), medical care, and treatment is assumed. In order to be in compliance with the Self-Determination Act (PSDA) and State laws and rules regarding advance directives, we will be asking if you have a living will. If you do not, this facility's staff will offer you information on how to make a living will. Because this is an ambulatory setting, any Advanced Directive to withhold resuscitation (CPR) will not be honored while you are in this facility. Should you suffer a cardiac or respiratory arrest or other life threatening emergency, we will provide resuscitation and transfer to a higher level of care.

Patient Complaint or Grievance

If you have a problem or complaint, please speak to the receptionist or your care giver. We will address your concerns promptly. If necessary, your problem or complaint will be advanced to an administrator for resolution. You will receive a letter or a phone call as a follow up.

If you are not satisfied with the response of the facility, you may contact:

Virginia Department of Health at 1-800-955-1819; AAAHC at 847-853-6060; Medicare Ombudsman 1-800-MEDICARE

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Consent for E-mail Correspondence and Electronic Communications

(Your binding signature for all electronic communication is your name and date of birth e.g. John Doe, 01/01/1980)

By providing your email to Fairfax Colon & Rectal Surgery, P.C. and/or Fairfax Colon & Rectal Surgical Center, L.L.C (collectively the "Practice"), you have agreed to correspond about limited subject matter using our website and/or electronic mail ("e-mail"). This form provides guidelines for the intended use of this type of communication.

Please be advised that the Practice does not encrypt e-mail messages. Therefore, e-mail communication between you and the Practice will not be conducted via a secure server, and may be able to be viewed by unintended persons. Further, be advised that should you provide the Practice with a work e-mail address, your employer may monitor all e-mail communications to that address, resulting in a disclosure to an unintended person. The Practice is not responsible for disclosures to unintended persons or for e-mail messages that are intercepted or lost due to technical failure during composition, transmission, and/or storage. The use of e-mail with the Practice may revoke or cancel any expectation of privacy afforded by the Doctor/Patient privilege and may jeopardize any privacy or expectation of confidentiality you may have regarding any protected health information contained in the e-mail communication.

Do not use e-mail to communicate medical emergencies to the Practice. If you are experiencing a medical emergency, DIAL 911. Do not use e-mail to ask medical questions. The Practice does not answer or respond to medical requests via e-mail. You must call the office at 703-280-2841 for ALL medical inquiries and requests.

The Practice does accept registration documentation including medical history and prescription refill requests to be communicated by e-mail. Only send this information if you are comfortable doing so.

The Practice will do its best to respond to your e-mail inquiries within seventy-two (72) hours of receipt by the Practice. If you have not received a response from the Practice in this timeframe, please call the office. Please be sure to identify yourself in your e-mail (**name and date of birth ONLY**), as well as the general topic of the message, which should be included in the "Subject" line of your e-mail. DO NOT include your Social Security Number or any credit card information in any e-mail.

You may at anytime indicate your decision not to receive email by sending written notice to the Practice of your decision. Likewise, the Practice may stop e-mail communication with you at anytime and for any reason, in which case further communications by the Practice will be conducted by telephone and/or U.S. mail.

The practice may use an automated appointment reminder system to notify you of your pending appointments.