Foot & Ankle Center of Florida LLC
2400 Harbor Blvd. Suite 11 Port Charlotte, FL 33952-5038
P: 941-500-2088 Fax: 941-500-2089
Email: FootAnkleCenterFL@comcast.com

CONCIERGE PLAN APPLICATION & AGREEMENT:

Patient Information:	
Name:	Date of Birth: Sex: ○ Male ○ Female
Address in Florida: City: State: ZIP:	Home #: ( )
Other Address if Outside of Florida: City: State/Country: ZIP:	Other #: ( )
Social Security #:	Cell #: ( )
Email address:	Other #: ( )
GUARANTOR INFORMATION	
Name:	Date of Birth: Sex: ○ Male ○ Female
Address: City: State: ZIP:	Home #: ( )
Other Address: City: State: ZIP:	Other #: ( )
Social Security #:	Cell #: ( )
Email address:	Other #: ( )
EMERGENCY CONTACT IF ANY DESIGNATED	
Name:	Date of Birth: Sex: ○ Male ○ Female
Address: City: State: ZIP:	Home #: ( )
Other Address: City: State: ZIP:	Other #: ( )
Social Security #:	Cell #: ( )
CONSENT TO BE PART OF THE CONCIERGE PLAN	
I the patient named above here by consent to enrollment in the Foot & Ankle Center of Florida LLC concierge plan that is being offered to me. I agree to the payment, my obligations, my financial obligations and to the obligations here by written forth below in the ensuing document here written:	
Patient Signature/Responsible Party:	Date:

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PRIMARY CARE PROVIDER	
Name of Provider:	
Address:	
Phone #:	
Email:	
VASCULAR PROVIDER	
Name of Provider:	
Address:	
Phone #:	
Email:	
CARDIOLOGIST PROVIDER	
Name of Provider:	
Address:	
Phone #:	
Email:	
NEUROLOGIST PROVIDER	
Name of Provider:	
Address:	
Phone #:	
Email:	
ENDOCRINOLOGIST PROVIDER	
Name of Provider:	
Address:	
Phone #:	
Email:	
PHARMACY USED	
Pharmacy name:	
Address:	
Phone #:	
Email:	
HOSPITAL USED/CHOICE	
Name of Provider:	
Address:	
Phone #:	
Email:	
LABORATORY USED	
Name of Provider:	
Address:	
Phone #:	
Email:	
DIALYSIS CENTER USED:	
Address /Phone#:	

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AUTHORIZATIONS

Authorization to Pay Benefits to Physician: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to myself or to my Provider, Foot & Ankle Center of Florida LLC when he accepts assignment.

Patient Signature:	Date:

Authorization to Release Medical Information: I hereby authorize my Provider, Foot & Ankle Center of Florida LLC to release any information necessary for my course of treatment.

Patient Signature:	Date:

I am aware of my HIPAA Rights and have been made aware of them by Foot & Ankle Center of Florida LLC providers and staff. I have been afforded the opportunity to read them in the office or to have them printed out for me at the reception desk.

Patient Signature:	Date:

I allow for copies of my records, insurance card, driver's license, personal picture of myself for records keeping and any digital image or recordings documenting my care, labs reports, x-rays or other diagnostic modalities to be used for reporting to insurance, governmental regulatory agencies, teaching purposes or publications where warranted or deemed necessary by Foot & Ankle Center of Florida LLC. I agree that students, residents, fellows, interns, technicians, assistants, other physicians or allied providers may observe or be involved in my care as long as they are supervised by appropriate faculty or a member of Foot & Ankle Center of Florida LLC staff designated as such.

Patient Signature:	Date:

I have been made aware of my financial obligations to Foot & Ankle Center of Florida LLC and realize that they will make every attempt to secure payment through my insurances or workers compensation claim. I understand that a referral is needed to seek Podiatric services and that is my obligation to get it prior to my appointment. I also understand that some podiatric services may not be covered by insurance and that I may be billed for them and will be responsible for them when provided. I will pay for collection services, attorney fees for Foot & Ankle Center of Florida LLC if they place my account in collections for failure to pay.

Patient Signature:	Date:

FINANCIAL POLICIES

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We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, or your financial responsibility. The patient or responsible party is responsible for seeing that the entire bill is paid in full. Responsible parties will be responsible for any collection fees, interest, and other expenses necessary to collect on any account, including court costs, should legal action be necessary to collect.

We will ask to see your insurance card on your first visit and will scan your card into our system as needed to keep our information current. We will ask for this information at every visit, in order to ensure that no change in benefits or carrier has occurred. Will also scan and retain you driver's license for collection purposes. Please notify us if your insurance carrier or policy has changed. Billing of insurance is a courtesy we provide for patients and is not required by law.

To be part of the Concierge Service Plan you will be billed an annual rate of **$1500.00** will designate your enrolled status to the service. All other fees and insurance arrangement will continue as any other visit as insured unless you are self-pay.

PLEASE READ AND INITIAL EACH LINE BELOW ACKNOWLEDING YOU HAVE READ ALL POLICIES.

INTIAL HERE	POLICY
	COPAYMENTS: Your insurance **REQUIRES** that we collect your designated co-pay at the time of service. Please be prepared to pay the co-pay at each visit.
	DEDUCTIBLES AND CO-INSURANCE: We may collect your deductible and co-insurance at the time of service. FACFL will bill your insurance company. Patient Responsibility portions of your bill are to be paid within 90 days.
	SELF-PAY/UNINSURED: Self-pay accounts shall exist if a patient has no insurance coverage or no evidence of insurance coverage. For new patients, a payment of **$350.00** is required on the day of your appointment before being seen by the health care provider. If you are unable to pay the **$350.00** please contact the billing office prior to your appointment. A discount off regular fees is offered for payment made at time of service.
	REFERRALS: If your insurance plan requires a referral from your primary care physician it is your responsibility to obtain it prior to your appointment and to have it with you at the time of the appointment. If you do not have your referral, **YOU MAY BE REQUIRED TO RESCHEDULE.**
	RETURNED CHECK FEES: Any returned check from the bank for non-payment (insufficient funds) shall result in the patient's account being assessed a **$50.00** fee per check returned.
	FORMS/PAPERWORK: There is a **$75.00 pre-payment** per form fee for the completion of paperwork or forms relating to disability, FMLA, etc. This fee is collected prior to completion of the paperwork, and for each time the paperwork is required. Allow seven working days for completion of forms. **Any forms needed within 48 hours from the time it was given to our staff will need to pre-pay an additional $50.00 rush fee.**
	DMV HANDICAP PARKING APPLICATIONS: There is a $25.00 fee for **ALL** DMV handicap parking applications.
	NO SHOW FEE: You will be charged a **$50.00 fee** if you fail to cancel your appointment with 24 hours of your scheduled appointment or do not show for your scheduled appointment.
	SURGERY CANCELATION FEE: Any surgeries cancelled within 7 business days of the scheduled surgery date will incur a **cancellation fee of $500.00. (Fee will be waived if surgery is canceled due to a death in the family, illness or if the patient is not cleared for surgery OR if our doctors determine a delay is needed.)**

Patient Signature/Responsible Party:	Date:
Patient Name if different from Responsible Party	Relationship to Party:

Acknowledgement Section / Request:

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Patient statement: To the best of my knowledge, the information I will provide is accurate and complete. Under Penalty of Perjury under laws of State of Florida and the Federal Statutes by which we are governed.	
Patient Signature:	Date:
I would have preferred to be reached by: ○ Home Phone ○ Cell Phone ○ Home Voice Mail. ○ Email:_____ ○ Our Patient Portal System May we leave messages on any of the above: ○ Yes ○ No	
Patient Signature:	Date:
PERSONS OR FAMILY MEMBERS THAT MY INFORMATION MAYBE RELEASED TO:	
NAME:	RELATIONSHIP:
NAME:	RELATIONSHIP:
NAME:	RELATIONSHIP:
Patient Signature:	Date:
CONSENT FOR TREATMENT	
I consent to and authorize the physician(s), physician assistant(s), nurse practitioner(s), resident physician(s), health care student(s) and/or clinical staff of Foot & Ankle Center of Florida or it's associates or affiliates or employees to provide diagnostic procedures and medical treatment including, but not limited to minor procedures and routine services deemed necessary at the time of the office visit, to me or the patient named on this form. I understand that the practice of medicine is not considered exact science and acknowledges that no guarantees have been made to the patient named on this form.	
Patient Signature/Responsible Party:	Date:
Patient Name if different from Responsible Party	Relationship to Party:

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OBLIGATIONS IN THE CONCIERGE PLAN:

- Service Amenities for the Foot & Ankle Center of Florida LLC Concierge Podiatric Medicine & Surgery Program provides premier service amenities as an adjunct to your Insurance health care services available in Florida. The service amenities currently offered by the Foot & Ankle Center of Florida LLC Concierge Podiatric Medicine & Surgery Program are listed below and can change without notice:
- **Payment:** You agree to pay an annual fee in the amount of **$1500.00** to become enrolled and is due in full payment at the time of registration. This can be paid by check or credit card.
- **Enrollment:** Your payment fee allows you to be enrolled for a period of **12 months** which begins at the time of payment receipt. The annual program fee only covers your enrollment in only the plan that is being offered. It does not retract any of your financial responsibilities to health care services or procedures being provided by the Foot & Ankle Center of Florida LLC. You and/or your insurance company will be financially responsible for all health care services received from Foot & Ankle Center of Florida LLC and staff. Foot & Ankle Center of Florida LLC will bill your health care insurance company provider for those health care services furnished to you and covered by such insurance. You are financially responsible for any health care services you receive that are not covered by your insurance. It in no way implies payment for any covered or non-covered service by your insurance plan. It is strictly a membership fee with our practice Foot & Ankle Center of Florida LLC.
- **Notifications of your Status:** You must notify the Foot & Ankle Center of Florida LLC Concierge Podiatric Medicine & Surgery Program as soon as possible of any changes in the information you have recorded concerning your insurance coverage or self-pay status.
- **Insured:** Medicare and private insurance companies require Foot & Ankle Center of Florida LLC to collect applicable co-payments, deductibles and other charges from patients for health care services rendered. Therefore, you will be financially responsible for the following charges, which are not part of the Annual Fee: Co-payments, co-insurance, or deductibles for any health care services received; and Charges for health care services not covered by health insurance. Your enrollment does not cover any health services provided and are coverable by your insurance they only cover your membership in the program.
- **Termination:** You may terminate this Agreement and your participation in the Foot & Ankle Center of Florida LLC Concierge Podiatric Medicine & Surgery Program at any time for any reason upon 60 days prior written notice to the Program. Foot & Ankle Center of Florida LLC Concierge Podiatric Medicine & Surgery Program may terminate this Agreement and your participation in the Program upon 30 days prior written notice to you – if any of the following occur (a) you fail to pay the Annual Fee or charges for health care services when due, (b) you fail to abide by the terms and conditions of your insurance coverage , (c) you fail to abide by the policies of Foot & Ankle Center of Florida LLC Concierge Podiatric Medicine & Surgery Program or Foot & Ankle Center of Florida LLC, or (d) your Foot & Ankle Center of Florida LLC ceases to participate in the Foot & Ankle Center of Florida LLC Concierge Podiatric Medicine & Surgery Program and you and Foot & Ankle Center of Florida LLC are not able to reach agreement on a replacement Foot & Ankle Center of Florida LLC Concierge Podiatric Medicine & Surgery Program for you. With thirty **(30) days** prior written notice, upon termination, Foot & Ankle Center of Florida LLC will refund a pro-rated portion of the Annual Fee based on the number of days that you have participated in the program
- **Program Modifications:/Discontinuance:** Foot & Ankle Center of Florida LLC may modify the Foot & Ankle Center of Florida LLC Concierge Podiatric Medicine & Surgery Program at any time, including changing the Foot & Ankle Center of Florida LLC Concierge Podiatric Medicine & Surgery Program physicians participation in the Foot & Ankle Center of Florida LLC Concierge Podiatric Medicine & Surgery Program or adding or elimination service amenities. In the event that you no longer wish to participate in the Foot & Ankle Center of Florida LLC Concierge Podiatric Medicine & Surgery Program after any such modification, you may terminate your participation in accordance with Section above. In addition, Foot & Ankle Center of Florida LLC may discontinue the Foot & Ankle Center of Florida LLC Concierge Podiatric Medicine & Surgery Program at any time. In the event Foot & Ankle Center of Florida LLC discontinues the Foot & Ankle Center of Florida LLC Concierge Podiatric Medicine & Surgery Program, Foot & Ankle Center of Florida LLC will take reasonable steps to transfer your care to another Foot & Ankle Center of Florida LLC physician and will refund a pro-rated portion of the Annual Fee based on the number of days that you have participated in the Foot & Ankle Center of Florida LLC Concierge Podiatric Medicine & Surgery Program.

- **E-mail Communications; Privacy.** If you wish to send secure e-mail communications to, and receive secure e-mail responses from, your Physician and/or his or her employees, agents and representatives, you should utilize the secure

messaging provided through your personal portal provided. You should be aware that unlike the secure messaging provided through your personal patient portal, traditional e-mail is not a secure medium for sending or receiving potentially sensitive personal health information. you also acknowledge and understand that e-mail in any form is not a good medium for urgent or time-sensitive communications. In the event a communication is time-sensitive you must communicate with your Physician by telephone or video-conference. You acknowledge and understand that, at the discretion of your Physician, your email may become part of your medical record. Patient agrees that email notification is not proper means of communication in the event of an emergency or a situation in which the member could reasonably expect to develop into an emergency, Member shall call 911 or the nearest Emergency room, and follow the directions of emergency personnel. If Patient does not receive a response to an e-mail message within one day, Patient agrees to use another means of communication to contact the Physician. Neither Foot & Ankle Center of Florida LLC, nor the Physician will be liable to Patient for any loss, cost, injury, or expense caused by, or resulting from, a delay in responding to Patient as a result of technical failures, including, but not limited to, (i) technical failures attributable to any internet service provider, (ii) power outages, failure of any electronic messaging software, or failure to properly address e-mail messages, (iii) failure of the Practice's computers or computer network, or faulty telephone or cable data transmission, (iv) any interception of e-mail communications by a third party; or (v) your failure to comply with the guidelines regarding use of e-mail communications set forth in this paragraph.

- **Change of Law.** If there is a change of any law, regulation or rule, federal, state or local, which affects the Agreement including these Terms & Conditions, which are incorporated by reference in the Agreement, or the activities of either party under the Agreement, or any change in the judicial or administrative interpretation of any such law, regulation or rule, and either party reasonably believes in good faith that the change will have a substantial adverse effect on that party's rights, obligations or operations associated with the Agreement, then that party may, upon written notice, require the other party to enter into good faith negotiations to renegotiate the terms of the Agreement including these Terms & Conditions. If the parties are unable to reach an agreement concerning the modification of the Agreement within **(30) days** after of date of the effective date of change, then either party may immediately terminate the Agreement by written notice to the other party
- **Amendment**. No amendment of this Agreement shall be binding on a party unless it is made in writing and signed by all the parties. Notwithstanding the foregoing, the Physician may unilaterally amend this Agreement to the extent required by federal, state, or local law or regulation ("Applicable Law") by sending You 30 days advance written notice of any such change. Any such changes are incorporated by reference into this Agreement without the need for signature by the parties and are effective as of the date established by Foot & Ankle Center of Florida LLC, except that Patient shall initial any such change at Foot & Ankle Center of Florida LLC request. Moreover, if Applicable Law requires this Agreement to contain provisions that are not expressly set forth in this Agreement, then, to the extent necessary, such provisions shall be incorporated by reference into this Agreement and shall be deemed a part of this Agreement as though they had been expressly set forth in this Agreement.
- **Governing Law.** This Agreement shall be governed by and construed in accordance with the laws of the state Florida in which your Foot & Ankle Center of Florida LLC is located.
- **Assignment**. This Agreement, and any rights Patient may have under it, may not be assigned or transferred by Patient.
- **Relationship of Parties.** Patient and the Physician intend and agree that the Physician, in performing his duties under this Agreement, is an independent contractor, as defined by the guidelines promulgated by the United States Internal Revenue Service and/or the United States Department of Labor, and the Physician shall have exclusive control of his work and the manner in which it is performed.
- **Legal Significance**. Patient acknowledges that this Agreement is a legal document and creates certain rights and responsibilities. Patient also acknowledges having had a reasonable time to seek legal advice regarding the Agreement and has either chosen not to do so or has done so and is satisfied with the terms and conditions of the Agreement.
- The patient agrees to pay for all legal services to collect, arbitrate or defend Foot & Ankle Center of Florida if any kind of dispute arise by having signed this agreement.

FOOT & ANKLE CENTER OF FLORIDA LLC OBLIGATIONS TO YOU UNDER CONCIERGE PLAN:

- Foot & Ankle Center of Florida LLC and the Foot & Ankle Center of Florida LLC Podiatric Medical and Surgical Concierge Program agrees to provide the following:

FOOT & ANKLE CENTER OF FLORIDA LLC

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- Schedule of Benefits Foot & Ankle Center of Florida LLC Podiatric Medical and Surgical Program Concierge. Which it currently provides, and which may change from time to time:

    - Your Foot Ankle Center of Florida LLC physician will provide enhanced communication and coordination of your care with others Medical Health Professional working with you and on your behalf and consult with them as needed or is necessary.
    - Executive physical and initial health assessment to develop the baseline medical profile to be integrated with individually designed and monitored medical, exercise plan
    - Access to your Foot Ankle Center of Florida LLC physician via his/her mobile phone, twenty-four hours a day, seven days a week*, when necessary
    - Enhanced access to your physician through E-Mail communication and electronic visits (i.e.: FaceTime and Skype) with your Foot Ankle Center of Florida LLC physician.
    - Personalized assistance with appointment scheduling and reminders for Foot Ankle Center of Florida LLC Podiatric Medical and Surgical Concierge Program and Foot Ankle Center of Florida LLC
    - Invitations to health-related presentations by Foot Ankle Center of Florida LLC physicians and professionals
    -

- • Direct contact with Foot Ankle Center of Florida LLC and staff during regular office hours

    - Providing Podiatric Medical and surgical Services. As used in this Agreement, the term Podiatric Medical and Surgical Services shall mean those medical services that the Physician, himself is permitted to perform under the laws of the State of Florida and that are consistent with his training and experience as a podiatric physician, as the case may be *Some restrictions apply The Physician may from time to time, due to vacations, sick days, and other similar situations, not be available to provide the services referred to above in this paragraph.
      1. During such times, Patient's calls to the Physician, or to the Physician's office, will be directed to a physician who is "covering" for the Physician during his absence. Foot & Ankle Center of Florida LLC will make every effort to arrange for coverage but cannot guarantee such coverage.
      2. Non-Medical, Personalized Services. Foot & Ankle Center of Florida LLC shall also provide Patient with the following nonmedical services ("Non-Medical Services"):
        - 24/7 Access. Patient shall have access to the Physician via instant messaging and video chat. Patient shall also have direct telephone and pager access to the Physician on a twenty-four hour per day, seven days per week basis. Patient shall be given a phone and pager number where patient may reach the Physician directly around the clock. During the Physician's absence for vacations, continuing medical education, illness, emergencies, or days off, Foot & Ankle Center of Florida LLC will provide the services of an appropriate licensed healthcare provider for assistance in obtaining podiatric medical and surgical services. Patient shall be given instructions as to how to contact such healthcare provider. Such provider shall be available to the Patient to the same extent as would the Physician, however provider shall be contacted through an answering service rather than through a direct phone line.
        - (b) E-Mail Access. Patient shall be given the Physician's e-mail address to which non-urgent communications can be addressed. Such communications shall be dealt with by the Physician or staff member of the Practice in a timely manner. Patient understands and agrees that email and the internet should never be used to access medical care in the event of an emergency, or any situation that Patient could reasonably expect may develop into an emergency. Patient agrees that in such situations, when a Patient cannot speak to Physician immediately in person or by telephone, that Patient shall call 911 or the nearest emergency medical assistance provider and follow the directions of emergency medical personnel.
        - (c) No Wait or Minimal wait Appointments. Every effort shall be made to assure that Patient is seen by the Physician immediately upon arriving for a scheduled office visit or after only a minimal wait. If Physician foresees a minimal wait time, Patient shall be contacted and advised of the projected wait time.

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- (d) Same Day/Next Day Appointments. When Patient calls or e-mails the Physician prior to noon on a normal office day (Monday through Friday) to schedule an appointment, every reasonable effort shall be made to schedule an appointment with the Physician on the same day. If the patient calls or emails the Physician after noon on a normal office day (Monday through Friday) to schedule an appointment, every reasonable effort shall be made to schedule Patient's appointment with the Physician on the following.

- No other assumptions or implied services or enhancements to services provided are made.
- No guarantees to outcomes of the patient from services provided are made or implied.
- This agreement is hereby signed on this date by both parties and is agreed too:

CONSENT BY PATIENT FOR CONCIERGE PLAN:

I consent to and authorize the clinical staff of Foot & Ankle Center of Florida or it's associates or affiliates or employees to Accept my enrollment membership in their Foot & Ankle Center of Florida LLC Podiatric Medicine and Surgery Concierge Plan. I understand that we will be bound by the terms of this agreement and I understand both party's obligations. I understand that my membership starts on date herby signed to and is only a membership enrollment fee. No other assumptions are implied for services to be rendered or enhancements to services being provided are made. No guarantees to outcomes of the patient from services provided are made or implied at this time.

Patient Signature/Responsible Party:	Date:
Patient Name if different from Responsible Party	Relationship to Party:

CONSENT BY FOOT & ANKLE CENTER OF FLORIDA LLC ACCEPTING PATIENT FOR ENROLLEMENT IN THE CONCIERGE PLAN: "Foot & Ankle Center of Florida LLC Podiatric Medicine and Surgery Concierge Plan":

Foot & Ankle Center of Florida LLC Delegated Representative:	Date:
Frank Louis Lepore DPM, MBA	Title: Owner/Founder/CEO NPI 1568451045. FL License# PO 3848