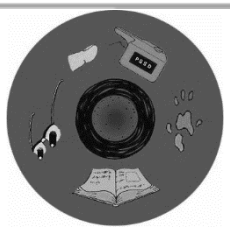
Patient Name: _____ DOB: _____ Date: _____

THE DELLON INSTITUTE FOR PERIPHERAL NERVE SURGERY



Eric H. Williams, MD

1122 Kenilworth Dr., Suite 18
Towson, MD 21204

Phone: 410-337-5400 Fax: 410-337-5520

Dear Sir or Madam:

Welcome to the Dellon Institute for Peripheral Nerve Surgery. We are pleased you have chosen us for your pain relief needs. In preparation for your first appointment, please find the attached New Patient Packet. We sincerely hope we can help you. Please read and complete the following information carefully so we can best determine how we can be of service.

Many patients who seek our services have complicated problems and have already been to multiple providers. With that in mind, please plan for a typical new patient consultation to last forty-five minutes to over one hour. Dr. Williams will give you his undivided attention and expertise so that your diagnosis and treatment are tailored to your unique problems and needs.

INSURANCE CARRIERS, FEES, AND ESTIMATED EXPENSE:

In regard to medical insurance, our patients fall into one of three categories outlined below. Please also be sure to read and understand the financial policy located in this packet. It will require your initials and signature prior to being seen in our office.

IN-NETWORK
Dr. Williams participates with the following commercial insurance carriers: Blue Cross and Blue Shield, United Healthcare, TriCare and Worker's Comp. For patients with one of these insurances, the office will submit your bills to your insurance company for reimbursement. You will be responsible for your copay/deductible at the time of your appointment. In the event that surgery is planned, surgical co-pay/deductible is due *prior* to your scheduled surgery.

OUT-OF-NETWORK and MEDICARE
So that we may focus our efforts on your care, Dr. Williams is an opt–out Medicare provider. Medicare patients are treated under private contract only. This means that patients are unable to submit their bill to Medicare for reimbursement and should therefore consider his fee an out-of-pocket expense.

Similarly, if Dr. Williams does not participate with your insurance carrier, you are also responsible for the full office visit fee. If you attempt to negotiate with your insurance company to obtain coverage for your visit, the full payment is still due and payable at the time of your consultation. Some patients are able to obtain in-network reimbursement rates for Dr. Williams' services because their insurance company does not have another physician in-network to provide these services. In this case, full payment for services is still required. The matter of reimbursement rates is between you and your insurance company. As payment, the office accepts cash, check, MasterCard and Visa.

The new patient office consultation fee ranges from $350 to $500, depending on the complexity of the office visit. Additional diagnostic testing may be necessary, including nerve blocks and/or in-office sensory testing. Nerve blocks range from $75-$400 and sensory testing from $75-$600. Depending on

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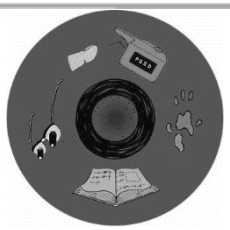

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each individual's needs, the total cost of a typical new patient visit can range from $500 to $1,000. Other diagnostic tests or lab work that may be needed can be performed at outside facilities participating with Medicare or your commercial insurance carrier. These will be billed and submitted to your insurance by that facility.

Dr. Williams does charge a fee for filling out various forms, such as FMLA forms, Disability forms, Medicare forms or preparation of special letters for lawyers or other. The cost of these forms depends on the complexity and time required to complete them and ranges from $25 – $250.

Additional information for our Medicare Patients:

If you carry secondary insurance through a commercial provider (for example, Blue Cross and Blue Shield, United Healthcare, Aetna, Cigna, or other), you may be eligible for benefits under this policy. It is your responsibility to contact your secondary insurance carrier and clarify any benefits. It is also your responsibility to apply for and manage your application for reimbursement. This office does not submit or manage claims to secondary insurance companies. You are advised to seek information regarding secondary coverage in advance of your first appointment. If needed, the office will provide you with an itemized receipt and any medical records necessary for you to apply for coverage under your secondary policy.

Additional information for our out-of-network patients:

The office will provide you with an itemized receipt, including diagnosis and procedure codes that will be needed to apply for reimbursement. If your insurance company requires any other documents or consult notes, we will be happy to provide you with them. You may, in turn, submit these forms to your insurance carrier for reimbursement. Per office policy, submission for out-of-network reimbursement is the patient's responsibility after the consultation. Any reimbursement provided by the insurance company will be sent directly to you.

It is highly recommended that you contact your insurance carrier in advance of this appointment and advise them that you are seeing Dr. Williams for consult. Ask them to clarify how reimbursement can be obtained for Dr. Williams' services and at what rate. Be sure to ask what forms they require and obtain them so you can review them in advance. It may be beneficial to inform them that you have determined that they do not have an in-network provider that you can see for this issue, and further you are requesting that they consider Dr. Williams consult fees and reimburse you according to in-network rates. Please be aware that reimbursement rates are widely variant.

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SURGERY

In the event that a surgical procedure is indicated and agreed to between the parties, there are 3 separate and distinct bills generated by the 3 different entities providing your surgical services:

1. Dr. Williams' surgical (professional) fee.
2. Facility Fees (i.e., operating room, circulating and scrub nurses, pre and post-surgical services, and supplies) - submitted directly to Medicare or insurance by the facility (Timonium Surgery Center, Union Memorial Hospital, GBMC or other)
3. Anesthesia fees - submitted directly to Medicare or insurance for anesthesia services.

Only Dr. Williams' surgical fee is paid in full by patients who are out-of-network or on Medicare. (In-network patients will pay the co-pay/deductible determined by their insurance company). The other fees will be billed and submitted to Medicare or your insurance company by the facility's staff. If you have questions regarding surgical procedures, costs and billing, they can be best answered after your consultation, when your diagnosis and proposed treatment have been determined by Dr. Williams.

Thank you for giving your time and attention to this packet. You may return the completed forms by faxing them to 410-337-5520, attention: New Patient Packet. You may also return them in person or through the US Postal Service to our office address listed above.

Feel free to contact the office if we may further assist you. We look forward to meeting you.

Sincerely,

The Staff
The Dellon Institute for Peripheral Nerve Surgery

THE DELLON INSTITUTE FOR PERIPHERAL NERVE SURGERY

Eric H. Williams, MD

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Meet the Doctor

Dr. Eric H. Williams graduated from Johns Hopkins School of Medicine in 1999 after receiving his undergraduate degree in Biology from Swarthmore College in the suburbs of Philadelphia, Pennsylvania. Dr. Williams completed his General Surgery Residency at Vanderbilt University Medical Center in Nashville, Tennessee in 2004. He then completed his Plastic Surgery Residency at the University of Alabama in Birmingham in June of 2006. Dr. Williams then completed another full year in fellowship training in Peripheral Nerve Surgery with Dr. A. Lee Dellon, a world renowned specialist in peripheral nerve surgery, in 2007.

Dr. Williams is board certified in General Surgery as well as Plastic and Reconstructive Surgery. After his fellowship, Dr. Williams was employed by The Dellon Institute for Peripheral Nerve Surgery for two additional years, until he became a full partner at The Dellon Institute in Baltimore, Maryland in 2010 dedicating the majority of his time to caring for the nerve injured patient.

His focus since 2007 has been centered on the surgical care and rehabilitation of lower extremity and upper extremity complex peripheral nerve syndromes with an emphasis in nerve injury, entrapment, and chronic regional pain syndromes, and diabetic peripheral neuropathy. Other areas of interest and expertise include groin pain, knee pain after knee replacement, intercostal nerve injury, and migraine headaches.

He has independently developed procedures to improve the sensation, pain, and muscle function in the lower extremity, and has been part of a team that has helped describe many other advancements in peripheral nerve surgery and peripheral nerve imaging. He has written and is co-author on many publications in the field.

While working in private practice, he is an Assistant Professor of Plastic and Reconstructive Surgery at Johns Hopkins University Medical Center in Baltimore, Maryland, and works closely with the Musculoskeletal Radiology Division to help improve the diagnostic capabilities of Magnetic Resonance Imaging of the peripheral nerve (MR Neurography).

Dr. Williams lives in Carroll County, MD with his wife, Bethany and their three children. Bethany works part-time at the Dellon Institutes. In his spare time, Dr. Williams' enjoys spending time with his family, gardening and hunting.

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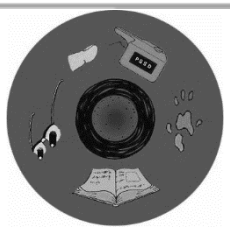

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DIRECTIONS

Office Location:
1122 Kenilworth Drive, Suite 18, The Exchange
Towson, MD 21204

GPS Navigation programed with this address should be reliable.

We are located in the back of "The Exchange" building. Once you enter "The Exchange" building entrance off of Kenilworth Dr., proceed down the drive, over the two speed bumps and make your first left turn into the parking lot.

Ample free parking is available in lot directly behind The Exchange office building. Our handicap accessible offices are conveniently located on the first floor. (No steps or elevator)

BWI Airport is the closest airport serving our area. However, arriving at the Washington DC area airports will only add approximately one hour to your trip north into Baltimore (depending on airport location and traffic).

Driving Directions:
FROM POINTS SOUTH AND BWI AIRPORT (Travel time approximately 35 minutes from the airport)
Exit the airport on Friendship Road (0.7 miles)
Slight Left at I-195W (signs for MD-170/I-95 Washington/Baltimore/I-295/Annapolis) (3.8 miles)
Take Exit 4A to merge onto I-95 North toward I-695/Baltimore (2.2 miles)
Take Exit 49B on the left and merge onto I-695 W/Baltimore Beltway Outer loop toward Towson (23 miles)
Take Exit 25 toward MD-139/Charles Street (0.2 miles)
Turn right at the stop light onto Charles Street (0.1 miles)
Turn Left onto Kenilworth drive (0.1 miles)
Take the first Left into The Exchange building.
Continue straight past The Exchange building and park in the bottom lot on the Left.
Our offices are located on the ground floor, with an outside entrance, in Suite 18.

FROM POINTS NORTH AT I-95 NORTH
Traveling South on I-95 towards Baltimore
Merge onto I-695 W/Baltimore Beltway Inner Loop via exit 64 toward I-70/I-83/Towson (17.5 miles)
Merge onto N Charles Street/MD-139 via Exit 25 toward Baltimore (0.7 miles)
Turn Left onto Bellona Ave. (420 ft.)
Take the first Left onto N Charles Street (0.3 miles)
Turn Left onto Kenilworth drive (350 ft.)
Take the first Left into The Exchange building.
Continue straight past The Exchange building and park in the bottom lot on the Left.
Our offices are located on the ground floor, with an outside entrance, in Suite 18.

For patients with access to the AMTRAK train, Baltimore's Penn Station is 11 miles, or about 15 minutes from our offices.

Please advise us if you need further assistance with hotel or transportation.

THE DELLON INSTITUTE FOR PERIPHERAL NERVE SURGERY

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Towson, MD 21204

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Hotel Recommendations

If you are in need of a hotel for your stay in the Baltimore area, the following are our recommendations:

Sheraton Baltimore North
Telephone: 410-321-7400 Contact Person: Sandy Jones
903 Dulaney Valley Road, Towson, MD 21204
Contact: Sandy Jones at Reservations and request the "Dellon Institute" rate.

Standard Room: Single/Double $115

Club Level: Single/Double $145

- Located 4 miles from the Timonium Surgery Center, 7 miles from Union Memorial Hospital, and 2 miles from our offices, also, connected to the Towson Town Center Mall, with many restaurants, and shops. They have a free shuttle to and from our office and to and from the surgery center.

- Club level offers complimentary breakfast, all day beverages and snacks, evening appetizers, beer and wine.

Crowne Plaza, Baltimore
Telephone: 410-252-7373
2004 Greenspring Drive, Timonium, MD 21093
Contact: Reservations and ask for "Dellon Institute" rate. **Guaranteed rate

Standard Room: Single/Double $95

- Located across the parking lot from the Timonium Surgery Center, and 4 miles from our offices

For Patients being operated on at Union Memorial Hospital:

Inn at the Colonnade, (Hilton Honors Hotel)
Telephone: 410-235-5400
4 West University Parkway, Baltimore, MD 21218
Contact: Reservations for "Dellon Institute" rate
*** Ask to please be connected to Chasity in-house reservations, and not to "Worldwide" reservations

Standard Room: Single/Double $109

Patient Name: _____ DOB: _____ Date: _____

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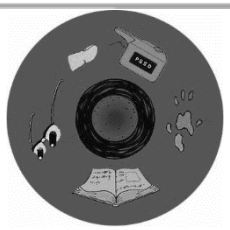

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Patient Demographics

Name:	Age:	DOB:	SSN:
Home Address:	City:	State:	Zip:
Home Phone:	Cell Phone:		
Email address:			
Occupation:	Work Phone:		
Work Address:	City:	State:	Zip:
Spouse (or parent if Minor):			
Spouse Employer:	Work Phone:		

Insurance Information

Primary Insurance:	
Claims Address (on back of card):	
Policy #:	Group #:
Policy Holder & Employer:	

Secondary Insurance:	
Claims Address (on back of card):	
Policy #:	Group #:
Policy Holder & Employer:	

Third Insurance (if applicable):
Is this a litigation case? YES / NO If yes – give name/address of Attorney in box below

Physician Information

Referring Physician:		Phone #:
Complete Address:		Fax #:
City:	State:	Zip:

Primary Physician:		Phone #:
Complete Address:		Fax #:
City:	State:	Zip:

Please list any other Dr.'s name, address, phone & fax # that you want to receive a copy of your consult:

DO YOU HAVE MEDICARE PART A OR B? YES / NO

_____ _____

Patient Signature Date

Patient Name: _____ DOB: _____ Date: _____

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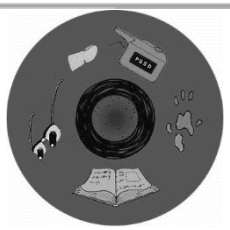

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Welcome to the Dellon Institute for Peripheral Nerve Surgery. Please take a few minutes to complete this form to the best of your ability. Your answers will help your doctor better understand your medical concerns.

Medical/Surgical History:
Problem you wish to discuss with your surgeon:

_____
_____

Age: _____ Gender: _____ Height: _____ Weight: _____

Circle: I am RIGHT / LEFT Handed

Have you had any of the following health problems which required treatment? If so, please check off below:

_____ Heart Disease
_____ Anemia
_____ Bleeding problems
_____ Blood clots
_____ High blood pressure
_____ Heart trouble or heart attacks
_____ Stroke
_____ Paralysis
_____ Sleep Apnea
_____ Diabetes
_____ Lung problems
_____ Asthma
_____ Emphysema
_____ Thyroid problems
_____ Hepatitis
_____ Kidney trouble
_____ HIV AIDS
_____ Depression
_____ Seizures
_____ Rectal trouble
_____ Arthritis
_____ Female problems
_____ Reflux
_____ Gallbladder problems
_____ Cancer
_____ Radiation (last treatment ____)
_____ Chemotherapy (last treatment ____)
_____ Other _____

Please list any prior surgeries:

Surgery	Date	Physician	Hospital

Patient Name: _____ DOB: _____ Date: _____

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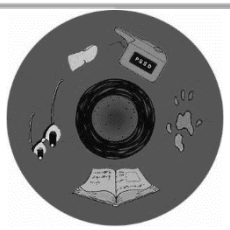

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Medications currently taking (please list all Rx meds, diet pills, over the counter meds & vitamins):

Medicine	Dose	Frequency	Medicine	Dose	Frequency

Do you have **latex** allergy? YES / NO. If yes, list reaction: _____

Do you have any **medication** allergies? YES / NO. If yes, list below:

Medication	Reaction	please circle
		very mild mild moderate severe
		very mild mild moderate severe
		very mild mild moderate severe
		very mild mild moderate severe
		very mild mild moderate severe
		very mild mild moderate severe
		very mild mild moderate severe
		very mild mild moderate severe
		very mild mild moderate severe
		very mild mild moderate severe

Diseases that run in your family: _____

Social History:

Do you smoke (please circle) CIGARETTES / CIGARS / PIPE?

[ ] Never [ ] Previous Smoker (quit date ____) [ ] Current Smoker

If you currently smoke: #packs/day #years you have smoked _____

Are you exposed to second hand smoke? [ ] yes [ ] no

Do you drink alcohol? [ ] yes [ ] no Drinks per week _____ For how long? _____

Do you use recreational drugs? [ ] yes [ ] no Have you used needles? [ ] yes [ ] no

Occupation: _____ Marital Status: _____

Name of Spouse: _____ # of children: _____

Patient Name: _____ DOB: _____ Date: _____

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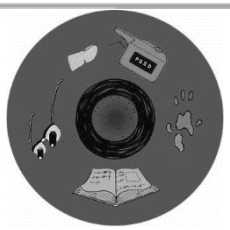

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Review of Systems: Please check any **current** problems you have on the list below:

Constitutional:
___ Fever
___ Chills
___ Night Sweats
___ Unexplained weight changes
___ Changes in energy/tiredness
___ Excessive thirst or urination

Eyes:
___ Dry Eyes
___ Changes in vision
___ Glaucoma
___ Cataracts

Ears, Nose & Throat:
___ Difficulty hearing
___ Ear pain
___ Sinus problems
___ Sore throat
___ Mouth ulcers
___ Teeth problems

Cardiovascular:
___ Chest pain/discomfort
___ Shortness of breath
___ Palpitations
___ Atrial Fibrilation (A.Fib.)
___ Mitral Valve Prolapse
___ Need antibiotics @ dental visits

Respiratory:
___ Coughing
___ Wheezing
___ Difficulty breathing

Gastrointestinal:
___ Abdominal pain
___ Nausea/vomiting
___ Blood in bowel movement
___ Diarrhea
___ Ulcers

Genitourinary
___ Incontinence (leaking urine)
___ Difficulty urinating
___ Pain during urination
___ Increased frequency
___ Discharge: penis or vagina

Musculoskeletal:
___ Muscle pain
___ Muscle weakness
___ Joint pain
___ Back pain
___ Swelling in extremities

Skin:
___ Rash
___ Mole changes
___ Non-healing wound

Neurological:
___ Loss of consciousness
___ Numbness
___ Dizziness
___ Headaches
___ Burning sensation
___ Tingling in fingers
___ Increased clumsiness or loss of coordination
___ Feeling like your hands/feet are falling asleep
___ Symptoms keep you awake at night

Psychiatric:
___ Anxiety/stress
___ Depression
___ Problems with sleep

Blood/Lymphatic:
___ Swollen glands
___ Easy bruising/bleeding
___ Blood Clots

Allergic/Immunologic:
___ Runny nose
___ Sinus Pressure
___ Itching

I certify that the above represents my complete and accurate medical and psychiatric history.

_____ _____
Signature of Patient Date

Patient Name: _____ DOB: _____ Date: _____

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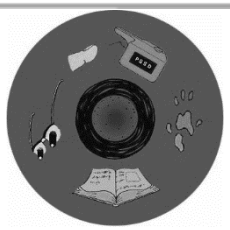
SURGERY



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Worker's Compensation Carrier

If your case involves Worker's Compensation, you must complete the information below before you will be able to be seen:

Worker Comp. Carrier:	
Carrier Address:	
Carrier Phone #:	Auth. Verified by:
Adjuster's Name and Phone #:	
Claim Number:	

Injury Information

Date of Injury:	Time of Injury:
Place of Injury:	
Accident reported to employer? YES / NO	Name of person reported to:
Give a full description of the accident:	
Have you lost time from work? YES / NO	If so, how much?
List other doctors you have seen for this condition:	
Were X-rays taken? YES / NO	Any other tests?
If yes, by which doctor and what were the results?	
Any previous Worker Compensation injuries? YES / NO	
Dates and description of previous injuries:	

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for the payment in the event that my claim for Worker's Compensation benefits is denied.

_____ _____

Patient's Signature **Date**

Patient Name: _____ DOB: _____ Date: _____

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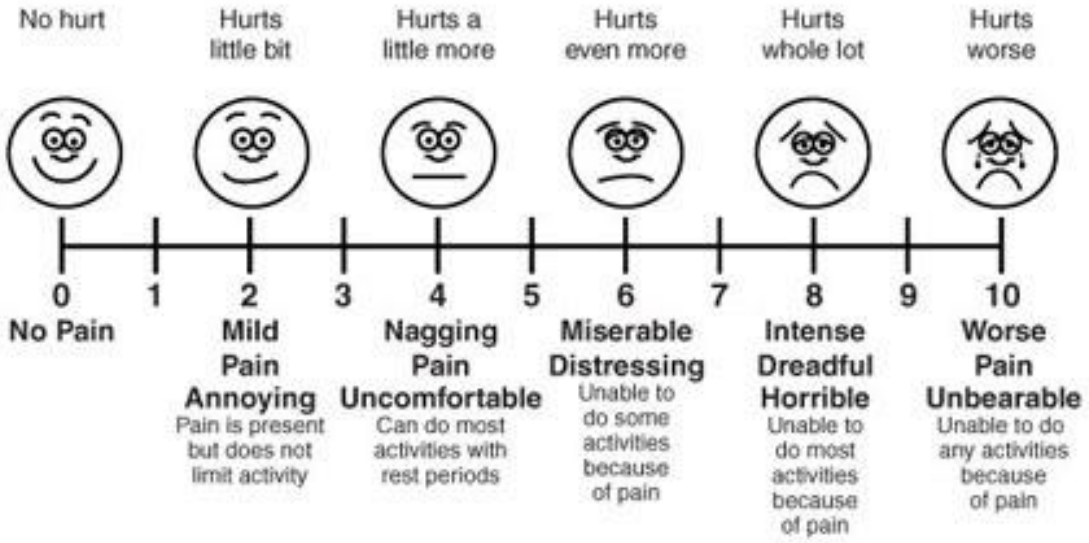
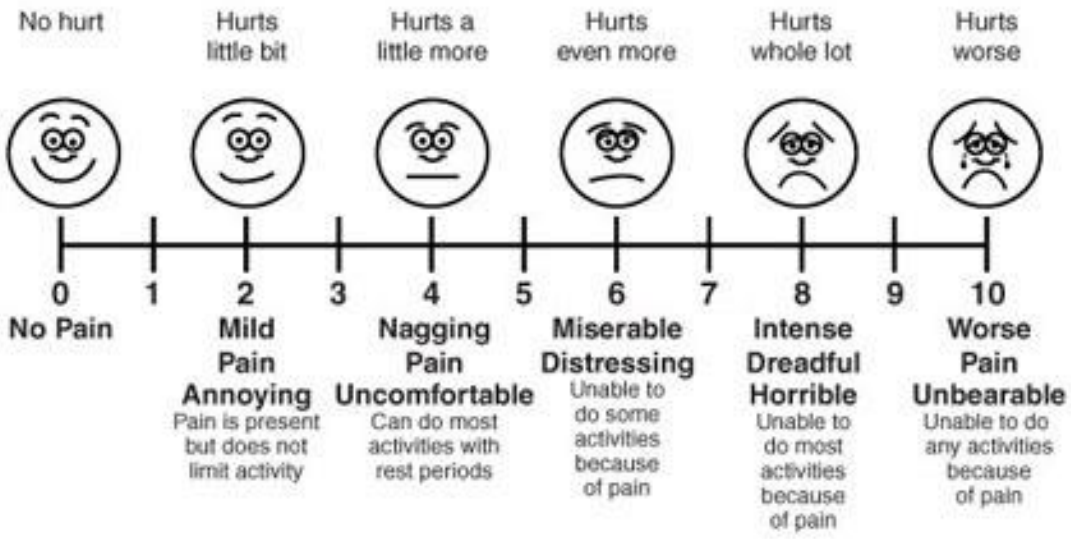
Pain Scale

The following pain scale is used to rate you pain levels at different times. Please circle the number that indicates the level of your pain over the recent past.

Rate the **WORST** pain you have felt recently:



Rate the **AVERAGE** pain you feel on a daily basis



Current activity levels: _____

Other Comments: _____

Patient Name: _____ DOB: _____ Date: _____

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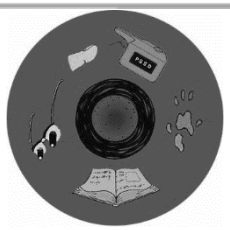
SURGERY



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FINANCIAL POLICY

We would like to thank you for choosing THE DELLON INSTITUTE FOR PERIPERAL NERVE SURGERY as part of your health care team. It is our sincerest desire to provide you with the most excellent personalized care. You can expect that we will spend the time needed to hear all of your concerns and collaborate with you to develop a care plan to address any and all issues that fall under our specialty. To that end, the following financial policy is in place to ensure that we can continue to be of service to you. We require your signature to document that you have read and understand these policies and agree to abide by them.

CANCELLED APPOINTMENTS AND NO SHOWS:

If you are unable to keep your scheduled appointment, please call our office 24 hours before your appointment to reschedule. This will allow time to provide that slot to another patient. The Practice reserves the right to charge $50.00 for appointments that are not cancelled at least 24 hours in advance.

Initials _____

INSURANCE:

It is the patient's responsibility to provide us with current insurance information and to present an active insurance card at each visit. If false, expired or incorrect insurance information is presented to us, you will be solely responsible for the fees incurred and payment will be required in full.

Initials _____

REFERRALS:

It is the patient's responsibility to provide a written referral for "Specialist Care" at the time of service. If the claim is denied due to lack of referral, the bill will be sent directly to you and payment to us will be immediately owed in full. It will then be the patient's responsibility to seek reimbursement from his or her insurance carriers.

Initials _____

CO-PAYMENTS:

Required insurance co-payments/deductible will be collected at the time of service. The Practice accepts cash, personal checks, VISA and Master Card. There is a service charge of $35.00 for returned checks.

Initials _____

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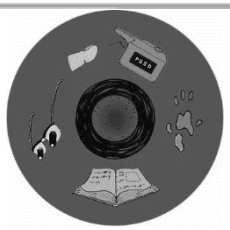

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OUT-OF-NETWORK:

If a patient is "OUT-OF-NETWORK," meaning the Practice does not participate with, and is not in a contract with, the patient's particular insurance carrier, it is the patient's responsibility to contact their insurance carrier for reimbursement. The Practice agrees to provide a receipt and your medical records that may be required. The Practice will not fill out reimbursement forms for the patient. Full payment for services is expected at the time of the visit. If your insurance carrier has agrees to reimburse you at "in-network" rates, payment of the full fee is still required at the time of the office visit. Reimbursement is between you and your insurance company.

Initials _____

SURGICAL PROCEDURES:

In the event that a patient elects to have a surgical procedure that has been recommended by the Practice, an ESTIMATE of the required patient's co-pay or deductible for the surgeon's fee will be given to the patient prior to scheduling the procedure. Surgical procedures will not be scheduled until the ESTIMATED co-pay is paid in full. The Practice cannot ensure the accuracy of the ESTIMATE, nor is it bound by the ESTIMATE. Insurance companies vary in covered costs. Because it is an ESTIMATE, the Practice may have to issue the patient a refund or credit for future care. If the ESTIMATE was too low, the patient shall promptly pay any additional amount owed once the insurance company has paid its portion of the bill. Please note that anesthesia and the operating facility will bill separately.

Initials _____

OUTSTANDING BALANCES:

Patients with an outstanding balance are expected to pay their balance in full at or before their next clinical appointment. If a patient does not pay their outstanding balance within 60 days from the date of service, the Practice reserves the right to transfer the account balance to an outside collection agency or attorney, or to take other such steps we deem necessary to collect your bill. If your account is referred to collection, you agree to pay our actual collection costs, including reasonable attorney's fees. Interest shall accrue on unpaid amounts at 10% per annum on the amount outstanding from the date due until paid in full. If a patient has an outstanding balance, elective care will be postponed until payment is made.

Initials _____

DISPUTE OF CHARGES

In the event that a dispute over charges arises after services have been rendered, I, the patient, waive my right to privacy under the Heath Information Portability and Accountability Act of 1996 (HIPPA) Guidelines. This means that I give permission for appropriate health information regarding services rendered to be shared with credit card companies and other creditors if requested to resolve a dispute.

Initials _____

Patient Name: _____ DOB: _____ Date: _____

THE DELLON INSTITUTE FOR PERIPHERAL NERVE SURGERY

Eric H. Williams, MD

1122 Kenilworth Dr., Suite 18
Towson, MD 21204

Phone: 410-337-5400 Fax: 410-337-5520

Please call our office if you have a question about your bill. Most problems can be settled quickly and easily and your call will prevent any misunderstandings.

FINANCIAL POLICY:

I HAVE CAREFULLY READ THIS ENTIRE FINANCIAL POLICY AND UNDERSTAND IT COMPLETELY. I AGREE TO THIS FINANCIAL POLICY OF THE DELLON INSTITUTE FOR PERIPHERAL NERVE SURGERY, BALTIMORE, MD., AND I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYING THE BILL FOR THE PRACTICE'S WORK AS SET OUT ABOVE.

_____ _____

Signature Patient/Guarantor Date

_____ _____

Print Patient's Name Date of Birth

ASSIGNMENT OF BENEFITS:

I hereby authorize the DELLON INSTITUTE FOR PERIPHERAL NERVE SURGERY to apply for benefits on my behalf for services rendered. I request and authorize payment from my insurer to be made directly to such physicians. The insurance information I have reported to you is correct and I authorize the release of any necessary information, including medical information for this or any related claim to my insurance company. A copy of this authorization may be used in place of the original.

_____ _____

Signature Patient/Guarantor Date

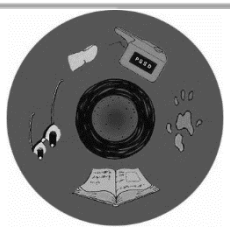
CONSENT TO TREAT:

I (or my legal guardian or parent) authorizes THE DELLON IN STITUTE FOR PERIPHERAL NERVE SURGERY to provide medical care reasonable by today's standards:

_____ _____

Signature Patient/Guarantor Date

THE DELLON INSTITUTE FOR
PERIPHERAL NERVE
SURGERY



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RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have received a copy of The Dellon Institute for Peripheral Nerve Surgery's notice of Privacy Practices.

**Check either of the options below as it pertains to the care and handling of your private information.

_____ I have reviewed and understand my rights pertaining the Privacy Act presented to me by The Dellon Institute for Peripheral Nerve Surgery. I give authorization for my medical information to be released to the following people, including records or medical information in reference to testing, office visits or surgeries I may have through this office.

_____ _____
Name of person Relationship

_____ _____
Name of person Relationship

OR

_____ I do not authorize release of my medical information to anyone other than myself.

_____ _____
Signature of Patient Date

Patient Name: _____ DOB: _____ Date: _____

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MEDICARE PRIVATE CONTRACTING NOTICE

ALL PATIENTS MUST SIGN THIS NOTICE REGARDLESS OF TYPE OF INSURANCE CARRIED

Eric H. Williams, MD has chosen to "opt-out" of the Medicare Program and is excluded from submitting claims to the Medicare Program. This private contract between the patient and Dr. Williams is a legal requirement by Medicare. The effective date of the opt-out period is September 30, 2016 and the expiration date of the opt-out period is September 30, 2018. This original document must be retained at the physician's office for the duration of the opt-out period. When the current opt-out period has expired, you will be required to sign a new contract with Dr. Williams.

You, the patient, understand, expressly acknowledge and agree to the following:

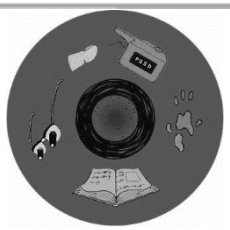
- You, as the patient, or your legal representative, accept(s) full responsibility for payment of Dr. Williams' charges for all services furnished by him.
- Medicare limits do not apply to the physician's charges for items or services provided or supplied.
- You and/or your legal beneficiary agree not to submit a claim to Medicare or ask Dr. Williams to submit a claim to Medicare.
- You and/or your legal beneficiary also understand(s) that Medicare payment will not be made for items or services furnished by the physician/practitioners that would otherwise have been covered by Medicare if you were not a party to this contract and a proper Medicare claim had been submitted.
- You and/or your beneficiary enter(s) into this contract with the knowledge that you have the right to obtain Medicare-covered items and services from physicians/practitioners who have not opted-out of Medicare and that you are not compelled to enter into private contracts that apply to other Medicare covered services furnished by other physicians or practitioners who have not opted out.
- You and/or your legal representative understand that Medi-gap plans do not make payments for items and services not paid by Medicare and that other supplemental insurance companies may likewise deny reimbursement.
- You and/or your legal beneficiary agree to reimburse the physician for any costs and reasonable attorney's fees that result from violation of this agreement by the patient or his beneficiaries.

I certify that I have not entered into this contract during a time when I required emergency care or emergency services and that a copy of this contract has been provided to me or my legal representative before services and items have been furnished under the terms of this contract.

Executed on _____ by _____ and Eric H. Williams, MD .
Date Print Patient Name Physician Name

_____ _____
Signature of Patient Signature of Physician, Eric H. Williams, MD

THE DELLON INSTITUTE FOR PERIPHERAL NERVE SURGERY



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AUTHORIZATION FOR USE AND DISCLOSURE OF IDENTIFIABLE HEALTH INFORMATION FOR PERIPHERAL NERVE SURGERY PROCEDURES AND TREATMENT

PATIENT:_____ DATE: _____ TIME: _____

Medical education is an important mission of The Dellon Institute for Peripheral Nerve Surgery (DIPNS). Often this education takes place outside of our office as Dr. Dellon and Dr. Williams share their knowledge with other physicians, institutions and faculty in the educational community. I have been asked to allow my identifiable health information (such as pictures or videos that can identify me) to be used for these outside educational purposes. I agree with the request and, in connection with this procedure or treatment, I authorized Dr. A. Lee Dellon and Dr. Eric H. Williams to use and disclose my identifiable health information in educational activities outside of DIPNS. These may include seminars, motion pictures, video conferencing and publication in textbooks, professional journals or electronic publications such as a website. My identifiable health information includes my actual photograph, a manipulated photograph to show possible outcomes, a drawing or similar illustrated graphic material, a motion picture image or digital image and other representations helpful in the educational process.

I hereby grant permission for the use of any of my medical records, including illustrations, photographs and other imaging records created in my case, for use in examination, testing, credentialing and/or certifying purposed by the American Board of Plastic Surgery, Inc. The American Board of Plastic Surgery requires that all identifiable characteristics, with the exception of a full face photograph or photograph of a uniquely identifiable characteristics, be blanked out for submission of material for the Oral Board Examination of The American Board of Plastic Surgery to protect patient privacy.

Even if my health information is used for the above activities and purposes, I understand that every effort will be made to use only those identifiers necessary for the activity. I also understand that DIPNS will make every effort to ensure that my information is used only as I authorize. However, since my information is disclosed, it may no longer be protected by federal and state privacy laws.

This authorization has no end date unless I cancel the authorization. I may cancel at any time in writing. I understand that if I cancel this authorization, the cancellation would affect only future disclosure of my information, photographs and images. However, if DIPNS has already taken action based on my authorization before the time of my cancellation, my cancellation will not affect that disclosure.

_____ _____
Signature Patient (or Agent/Guardian/Parent/Personal Representative – circle one) Date

Address: _____ Phone: _____

If you are the healthcare agent or guardian or court appointed personal representative of the patient, please attach proof of your authority to act on behalf of the patient.

I may revoke this authorization by mailing or faxing my written request along with a copy of the original authorization to DIPNS. If I am unable to provide a copy of the original authorization with my request to revoke, I will proved the following information: Name, Address, Phone Number, Social Security Number, Date of Birth, Date of Authorization, Purposes of authorization, a description of the health information covered by this authorization and the person or entity authorized to use the data. If the form was signed by the Patient's representative, the request will also include the representative's name, relationship, address and phone number. I understand that if I am unable to provide all of the above information, DIPNS may not be able to honor my revocation request.

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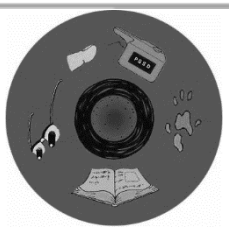

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Consent for Release of Health Information

For the purpose of continuity of care, release of the protected health information of:

Patient Name: _____ DOB: _____ SSN: _____

Street Address: _____ City: _____

State: _____ Zip: _____ Phone Number: _____

May be released:

please check:
__ TO
__ FROM

The Dellon Institutes for Peripheral Nerve Surgery
1122 Kenilworth Drive, Suite 18
Towson, MD 21204
Phone: (410) 337-5400 Fax: (410) 337-5520

please check:
__ TO
__ FROM

Other Doctor/Practice: _____ Fax Number: _____
Name: _____ Fax Number: _____
Name: _____ Fax Number: _____
Name: _____ Fax Number: _____

The information I wish to have released includes (dates of service) _____:

◯ History and physical exams
◯ Reports of Operations
◯ Imaging
◯ Diagnostic study reports
◯ Laboratory reports
◯ Consultation reports
◯ Discharge Summary
◯ Other _____

I do __ I do not __ wish to have information about HIV/AIDS released under this authorization.
I do __ I do not __ wish to have mental health records released under this authorization.
I do __ I do not __ wish to have information about drug/alcohol abuse treatment released under this authorization.

If DIPNS or the other doctor/practice is in possession of records from another provider, I do __ do not __ wish to have those records released under this authorization.

This authorization will expire one year from the date it is signed. This authorization to disclose information may be revoked by me, in writing, at any time, except to the extent that action has been taken prior to receipt of revocation.

_____ _____
Patient or Personal Representative Signature Date

If signature is other than patient, explain your authority to act for the patient:
_____
_____

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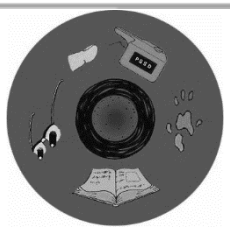
SURGERY



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SIGNATURE ON FILE

I authorize the use of this form on all of my insurance submissions.
I authorize release of information to all of my Insurance Companies.
I understand that I am responsible for my bill.
I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.
I authorize payment to be made directly to my doctor.
I permit a copy of this authorization to be used in place of the original.

Name: _____

Signature: _____