NOTICE OF GENERAL DISCLAIMERS

AUTHORIZATION FOR MEDICAL CARE & RELEASE OF INFORMATION

I hereby authorize **Ross Nathan, M.D. Inc., KMK Clinical, Inc. and The Hand & Wrist Center** [collectively referred to as ***The Hand & Wrist Center***] to render necessary medical services to me for the purposes of treating and curing my medical condition. I understand that in providing care to me, the Physician(s) and staff, may require additional medical information. Therefore, I hereby give authorization for ***The Hand & Wrist Center*** to obtain any of my medical information from previous, present and future treating Physicians, and/or other medical providers and facilities for the duration of my treatment. I also authorize ***The Hand & Wrist Center***, and their billing facility, to furnish information to any insurance carrier that I am filing a claim with for the purpose of payment concerning my treatment, as well as any entity requiring information for the purposes of further treatment regarding my illness/condition. A copy of this authorization shall serve as valid as the original.

DURABLE MEDICAL EQUIPMENT (DME) / SUPPLIES / OTHER MISCELLANEOUS SERVICES WAIVER

Certain medical conditions may require the use of DME, supplies and other miscellaneous services, which include any of the following: pre-fabricated and custom-fabricated casts, splints/braces, dressings, slings, cushions, injections, etc. Although these are considered to be "medically necessary" by my Physician, many insurance carriers may deny payment of such items. If I am covered by private insurance, I understand that ***The Hand & Wrist Center*** will bill my insurance carrier for these items in good faith; however, if it is known beforehand, ***The Hand & Wrist Center*** will require pre-payment for non-covered items (note: many insurance carriers consider pre-fabricated splints to be non-covered items). In the event that billed items are denied by my carrier, I will be held responsible for paying these non-covered items. For pre-determined, non-covered items, payment is due when the item is dispensed and I understand that there are two methods for payment: (1) Cash or personal check, and (2) Credit Card (Visa, MasterCard and Discover). Additionally, if I pay with a check, I understand that there is a **$30.00 Non-sufficient funds (NSF) fee** that will be added to all returned checks. A copy of this authorization shall serve as valid as the original.

ASSIGNMENT OF BENEFITS/PAYMENT AGREEMENT POLICY

If I am insured, I request that ***The Hand & Wrist Center*** submit their bills to my insurance plan. I request that my insurance plan submit payment to **Ross Nathan, M.D., Kourosh M. Kolahi, M.D. or *The Hand & Wrist Center*** on my behalf, for any services provided to me. I authorize any holder of my medical (or other-related) information to be released to any entity (which may/may not include any insurance company, Medicare and its affiliate agents, and/or any other government or private payer) for the purposes of paying for my services. I understand that it is my responsibility to know if ***The Hand & Wrist Center*** is an approved medical provider for my insurance plan. In the event that either Physician is not an approved medical provider, I acknowledge that I will be responsible for paying for any services and/or items not covered by my insurance plan. I understand that co-pays, deductibles, and other pre-determined costs are due at the time of my treatment. All unpaid claims, outstanding balances, and any other insurance payment denial is my responsibility to pay. I hereby agree to pay for all accrued charges until my account is satisfied in full. I am responsible for responding to any correspondence sent to me by ***The Hand & Wrist Center*** and/or its billing service, and therefore, I understand that it is my responsibility to inform ***The Hand & Wrist Center*** of my correct mailing address so that all correspondence can be mailed to me. I understand that if I fail to pay my account balance, **unpaid balances will accrue interest at the rate of 1.5% monthly (18% annually).** I acknowledge that any failure to respond to billing correspondence will result in my account being forwarded to a Collection Agency with an added **Collection Fee of $50.00 or 30% of the balance, whichever is greater.** If I am a Cash-paying patient, I understand that "payment in full" is due at the time services are rendered. If I pay with a check, I understand that there is a **$30.00 Non-sufficient funds (NSF) fee** that will be **added** to all returned checks. If I am insured through Workers' Compensation, I understand that it is my responsibility to ensure that my employer has filed a formal claim with their Workers' Compensation carrier, and that this information is immediately available to ***The Hand & Wrist Center***. Failure to facilitate any of the above requirements will result in my direct responsibility for all charges as stated in this section. A copy of this authorization shall serve as valid as the original.

NOTICE OF PRIVACY PRACTICES RECEIPT: (F3.2B) HIPAA POLICIES AND PROCEDURES

NAME OF PRACTICE:	**ROSS NATHAN, M.D., INC., KMK CLINICAL, INC., *THE HAND & WRIST CENTER***
ADDRESS:	3918 LONG BEACH BOULEVARD SUITE 100, LONG BEACH CALIFORNIA 90807
PRIVACY OFFICIAL:	**ROSS NATHAN, M.D. AND KOUROSH M. KOLAHI, M.D. (PRACTICE OWNERS)**
TELEPHONE:	(562) 424-9000

I acknowledge that I was provided the ability to review and receive a copy of the **Notice of Privacy Practices** of the medical practice(s) named above.

NOTICE OF MEDICAL DISPUTE RESOLUTION

I understand that **Ross Nathan, M.D., Inc., KMK Clinical, Inc. and *The Hand & Wrist Center*** reserves the right to institute "Third-party Mediation" as a standard resolution method for medical disputes should they arise. I understand that "Mediation" is defined as an "alternative dispute resolution" method in which disputing parties (at their own expense) "work with a neutral third party called a 'mediator,' who facilitates the resolution of the parties' disputes by supervising the exchange of information and the bargaining process," including but not limited to "…helping the parties find common ground and deal with unrealistic expectations" (source: http://adr.findlaw.com/mediation/what-is-mediation-.html). If medical disputes arise, I agree to "Third-party Mediation" resolution unless collectively it is decided that mediation is not appropriate for any reason and/or it is decided that disputes are best resolved in a traditional court setting. I understand that (at any time) I have the right to further discuss the Medical Dispute Resolution process with my Physician and/or any designated representative of ***The Hand & Wrist Center***. I also understand that my disagreement to any part of the Medical Dispute Resolution process described within (at any time) can serve as reasonable grounds to be terminated from care. A copy of this signed authorization shall serve as valid as the original.

PATIENT NAME: _____ **SIGNATURE:** _____

DATE: _____

FOR REPRESENTATIVE/GUARDIAN OF THE PATIENT (IF APPLICABLE):

NAME: _____ SIGNATURE: _____

RELATIONSHIP: _____ (PARENT, LEGAL GUARDIAN, POWER OF ATTORNEY, ETC.)

PATIENT'S ID/CHART #: _____ (**HWC 11-01-20)**