THE HAND & WRIST CENTER

MEDICARE (AND MEDI-GAP) ACKNOWLEDGMENT FORM

This notice contains important notices for Medicare patients. Despite your signed designation, some services may not be covered by Medicare or Medi-Gap benefits. Before deciding to accept or decline services and products, please do the following:

- Ask our staff to explain to you why Medicare may not pay for certain services and products
- Ask our staff how much services and products will cost (in case you must pay for these)
- Ask our Physicians to explain the importance of receiving certain services and products.

ADVANCE BENEFICIARY NOTICE (ABN) / NOTICE OF EXCLUSIONS

Ross Nathan, M.D. (of Ross Nathan, M.D. Inc.), Kourosh M. Kolahi, M.D. (of KMK Clinical, Inc.) and The Hand & Wrist Center [collectively referred to as ***The Hand & Wrist Center***] are contracted Medicare providers.

Medicare **may not** pay for the following services and products provided by our Center:

- In-office procedures or other "same-day" services
- Surgical procedures – including the services of surgical assistants
- Durable Medical Equipment (DME) – including prefabricated and custom-made splints, slings, casts and other similar items
- Dressings/bandages (and all related supplies)
- Occupational Therapy (and related services and products)
- Personal comfort items (regardless if determined to be medically necessary)
- "Other services" provided by non-affiliated entities (i.e. MRIs, CT scans, nerve studies, laboratory studies and other similar services)
- Medications prescribed by our Physicians
- Any items provided to any patient who is a resident of a skilled nursing facility, or a part of a skilled nursing facility (unless under arrangements by the skilled nursing facility)

For a complete, updated summary of non-covered items, please contact the *Centers for Medicare and Medicaid Services* at 1-800-MEDICARE (1-800-633-4227) or visit www.cms.hhs.gov .

MEDICARE SIGNATURE ON-FILE

With my signature below, I request the ***Centers for Medicare and Medicaid Services*** to make payment, for services provided to me, to **Ross Nathan, M.D., Kourosh M. Kolahi, M.D. or *The Hand & Wrist Center.*** I also request Medi-Gap (supplemental) insurance benefits to be made payable to **Ross Nathan, M.D., Kourosh M. Kolahi, M.D. or *The Hand & Wrist Center***. I authorize my signature below to be used for both paper and electronic claim submissions.

I authorize any holder of my medical information to release this information to Medicare, my Medi-Gap carrier and their agents for the purpose of paying **Ross Nathan, M.D., Kourosh M. Kolahi, M.D. or *The Hand & Wrist Center*** for services provided to me.

Patient's Name: _____ Medicare Number: _____

Name of Medi-Gap Insurer: _____ Medi-Gap policy number: _____

Provider Name(s): **Ross Nathan, M.D.**
Kourosh M. Kolahi, M.D.
The Hand & Wrist Center
3633 Long Beach Boulevard Suite 100, Long Beach CA 90807

I accept that services, products and account balances that are not paid by Medicare or Medi-Gap benefits will be billed directly to me, in accordance to this notice.

PATIENT SIGNATURE: _____ **DATE:** _____