

## NOTICE OF GENERAL DISCLAIMERS

### AUTHORIZATION FOR MEDICAL CARE & RELEASE OF INFORMATION

I hereby authorize **Ross Nathan, M.D. Inc. DBA The Hand & Wrist Center** and/or **George A. Macer, M.D. Medical Corporation** (within 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 or MasterCard). 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.**, and/or **George A. Macer, M.D.**, 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 **Dr. Ross Nathan** and/or **Dr. George A. Macer** 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 correspondence can be mailed to me. I acknowledge that any failure to respond to correspondence will result in my account being forwarded to a Collection Agency. I understand that if I fail to pay my account balance, my account will be sent to a Collection Agency and a **Collection Fee of forty (40) percent (of the entire remaining balance)** will be added to my account, which I will also be responsible to pay. 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

<b>NAME OF PRACTICE:</b>	<b>ROSS NATHAN, M.D., INC. DBA THE HAND &amp; WRIST CENTER; GEORGE A. MACER, JR., M.D., CORP.</b>
<b>ADDRESS:</b>	3918 LONG BEACH BOULEVARD SUITE 100, LONG BEACH CALIFORNIA 90807
<b>PRIVACY OFFICIAL:</b>	<b>AMANDA MERINO</b>
<b>TELEPHONE:</b>	(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 ARBITRATION

I understand that **Ross Nathan, M.D., Inc., DBA The Hand & Wrist Center**, and **George A. Macer, Jr., M.D., Corp.**, institute the practice of Arbitration as resolution for all medical disputes should they arise. I have been granted the opportunity to review and sign the formal Arbitration agreement, but I may also choose not to sign it. I understand that as a result of not signing the Arbitration form, my Physician reserves the right to provide me with consultation only for my condition, and reserves the right not to provide me with actual treatment. I acknowledge that in the event that Arbitration is required, and/or if I am dissatisfied with the decision, I have the opportunity, at my own expense, to appeal the decision and/or request reconsideration of the decision in a court setting. I also understand that I have the opportunity to further discuss the Arbitration process with my Physician and/or any designated representative of **The Hand & Wrist Center**. A copy of this authorization shall serve as valid as the original.

**PATIENT NAME:** \_\_\_\_\_ **SIGNATURE:** \_\_\_\_\_

### FOR PERSONAL REPRESENTATIVE/GAURDIAN OF THE PATIENT (IF APPLICABLE):

**NAME:** \_\_\_\_\_ **SIGNATURE:** \_\_\_\_\_

**RELATIONSHIP:** \_\_\_\_\_ (PARENT, LEGAL GUARDIAN, POWER OF ATTORNEY, ETC.)

**DATE:** \_\_\_\_\_

**PATIENT'S ID/CHART #:** \_\_\_\_\_