



AUTHORIZATION FOR MEDICAL CARE & RELEASE OF INFORMATION

I hereby authorize **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(s) that I am filing a claim with for the purposes of coverage concerning my illness/condition and 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/SUPPLIES WAIVER FORM:

Certain medical conditions may, or may not, require the use of durable medical equipment/supplies, which include any of the following: pre-fabricated and custom-fabricated casts, splints/braces, dressings, slings, cushions, 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 it is the policy of **The Hand & Wrist Center** to bill my insurance carrier(s) for certain items (note: many insurance companies consider pre-fabricated/"off the shelf" splints to be non-covered items). In the event that these items are denied by my insurance, I will be held responsible for paying any outstanding bills regarding such items issued. 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 (no third-party checks), and (2) Credit Card payment (Visa or MasterCard).

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 medical and other information (relating to me) to be released to any entity (which may or may not include any insurance company, Medicare and its affiliate agents, assistance agencies, and/or any other government or private payer) for the purposes of paying for any services provided to me. 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 for my insurance plan, I acknowledge that I will be responsible to pay for any services and/or products not covered by my insurance plan. I also understand that co-pays, deductibles, and other pre-determined costs are due at the time of my treatment. All unpaid claims, open-account balances, and any other payment denial by my insurance plan is my responsibility to cover. I hereby agree to pay for all accrued charges until my account is satisfied in full. I will be held responsible to respond to any correspondence furnished to me by **The Hand & Wrist Center**, or it's billing service, and I acknowledge that any failure on my part to respond to such will result in my account information being forwarded to a collection agency. If I am a Cash-paying patient, I understand that "payment in full" is due at the time service is rendered. If I am insured through Workers' Compensation, I understand that it is my responsibility to ensure that my employer has filed a formal claim to their Workers' Compensation carrier, and that this information is made readily available to **The Hand & Wrist Center**. Failure to participate in achieving such will result in my direct responsibility for all charges as stated in this section.

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

NAME OF PRACTICE: THE HAND & WRIST CENTER; ROSS NATHAN, M.D., INC.; GEORGE A. MACER, JR., M.D., CORP.
ADDRESS: 3918 LONG BEACH BOULEVARD SUITE 100, LONG BEACH CALIFORNIA 90807
PRIVACY OFFICIAL: AMANDA MERINO
TELEPHONE: (562) 424-9000

I acknowledge that I was provided with the ability and opportunity to review and receive, or not receive, a copy of the Notice of Privacy Practices of the medical practice(s) named above.

NOTICE OF ARBITRATION

I understand that **The Hand & Wrist Center, Ross Nathan, M.D., Inc., and George A. Macer, Jr., M.D., Corp.**, institute the practice of Arbitration as resolution for all medical disputes if they should 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, 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, Ross Nathan, M.D., Inc., and George A. Macer, Jr., M.D., Corp.**

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 #: _____