CONCIERGE CARPAL TUNNEL and HAND SURGERY

Financial Policy

The following is our financial policy. This must be read, understood, and signed prior to receiving treatment. If you have any questions about this policy, please ask for our manager/billing department.

Insurance: Concierge Carpal Tunnel and Hand Surgery does not take insurance.

Payment: We do require payment at the time of arrival prior to any consultation. Additional payments are due at time of service for extra services provided beyond the initial consultation (*X-rays, injections, casting etc.)* We accept most major credit cards, cashier's check, cash, Care Credit Financing, and cryptocurrency (Bitcoin and Ethereum).

Cancellation Policy:

A 24-hour notice must be given if I need to cancel or change my appointment, so that no charges will be incurred for late cancellation of appointments. If the patient "no calls" or "no shows" to the appointment or does not cancel their appointment ahead of the 24-hour policy, they will be subject to a $**40 cancellation fee**.

Agreements: In consideration of the treatment provided, the undersigned agrees:

1. I understand that I will pay for any treatment at the time of service.
2. To the cancellation policy in its entirety
3. That I have read the Financial Policy and understand and accept the terms of this Financial Policy

Signature: _____

Date: _____

Relationship to patient (If signed by representative of patient): _____

Witness Signature **(OFFICE STAFF ONLY)** Date

CONCIERGE CARPAL TUNNEL and HAND SURGERY

REFUND POLICY

At Concierge Carpal Tunnel and Hand Surgery, we understand the financial risk and obligation incurred when being treated by a specialist. After your treatment is complete, there **MAY BE** a credit balance on your account in some instances. In this case, CCTHS will contact patients who have an overpayment on their account greater than $5.00, so this can be refunded directly to them. A Concierge Carpal Tunnel and Hand Surgery team member will contact the patient directly so it can be determined how to go about moving forward with the refund. It is imperative you provide us with appropriate, working contact information so we can contact you if such a situation arises.

Patient Signature

Date

CONCIERGE CARPAL TUNNEL and HAND SURGERY

HIPAA Notice of Privacy Practices

1. Policy regarding confidentiality of all forms of Patient Records. All PHI regardless of its form, mechanism of transmission, or storage is to be kept confidential. Only individuals with a business need to know are allowed to view, read, or discuss any part of a patient's PHI. During initial new hire orientation and at annual HIPAA training employees are reminded that any viewing, reading, or discussions of PHI that is not for business purposes is prohibited. An employee who violates this confidentiality policy will be subject to sanctions up to immediate termination. All employees are required to verify in writing that they have read and will comply with our policy regarding confidentiality of all forms of PHI.

2. All PHI transmitted to third parties will be transmitted on secured lines. The security of transmission lines will be verified via contract with third party responsible for transmitting our patient's PHI. A signed medical records release is necessary for any medical records requests.

3. No digitally stored PHI shall leave this facility.

4. Policy regarding charges for e-copies of medical records. The Privacy Rule permits the Covered Entity (Concierge Carpal Tunnel and Hand Surgery) to impose reasonable, cost-based fees for paper copies. The fee for copies is .60 cents per page.

5. Document Retention Policy: All HIPAA documentation such as policy and procedures, risk assessment, incident investigation, breach notification, and training records will be maintained for at least six years.

Patient Name: _____

Date of Birth: _____

I have received and understand this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices and to make changes regarding all protected health information, resident at, or controlled by this practice. If changes to the policy occur, this practice will provide me a revised Notice of the Privacy Practices upon Request.

Signature: _____

Date: _____

Relationship to patient (If signed by representative of patient): _____

CONCIERGE CARPAL TUNNEL and HAND SURGERY

I _____, HEREBY REQUEST THAT COPIES OF MY MEDICAL RECORDS AND TESTS BE RELEASED TO:

Concierge Carpal Tunnel and Hand Surgery

Ryan J. Grabow, MD
3175 St. Rose Pkwy #330
Henderson, Nv 89052
Phone: 702-433-9533
Fax: 702-478-5492

I authorize Concierge Carpal Tunnel and Hand Surgery: Dr. Ryan J. Grabow and or their agents to obtain my medical records from other physicians or parties. A photocopy of this form may be used in lieu of the original.

Please Include all the Following to be released:

( )The Entire Medical Record

( ) All Radiology Tests: ( ) X-rays, ( ) Cat Scans, ( ) MRI, ( ) Other: _____

( ) Specific Dates Of Service: ___/___/_____ to ___/___/_____.

Patients Name: _____

Date of Birth: ____/____/_____ Social Security #:_____

Affirmation of Release:
By signing below, I give my permission to release my medical records and studies to Concierge Carpal Tunnel and Hand Surgery. I understand that this release is valid for up to one year from the date of signature and I may revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. Any revocation or refusal to sign this authorization will not prevent medical treatment or payment. I understand that a revocation must be sent in writing.

_____ _____
Signature of Patient/Guardian/Legal Representative Date

*HIPPA Regulations require that the following statement be present on this release: The information disclosed may be subject to redisclosure by recipient and no longer protected. This authorization may be revoked at any time.

CONCIERGE CARPAL TUNNEL and HAND SURGERY

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by Nevada law, and not by a lawsuit or resort to court process except as Nevada law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are voluntarily giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration.

Article 2: All Claims Must Be Arbitrated: It is the intention of the parties that this agreement shall cover all existing or subsequent claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by the below identified physician, medical group or association, their partners, associates, associations, corporations, partnerships, employees, agents, clinics, and/or providers (hereinafter collectively referred to as "Physician") to a patient, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.
Filing by Physician of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against Physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: Procedures and Applicable Law: A notice or demand for arbitration must be communicated in writing by U.S. mail, postage prepaid, to all parties, describing the claim against Physician, the amount of damages sought, and the names, addresses and telephone numbers of the patient, and (if applicable) his/her attorney. The parties shall thereafter select an arbitrator to preside over the matter who was previously a court judge. Both parties agree the arbitration shall be governed pursuant to Nevada Revised Statutes (NRS) 38.206 – 38.248, 41A.035, .045, .097, .100, .110, .120, 42.005 and .021 and the Federal Arbitration Act (9 U.S.C. §§ 1-4), and that they have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. The parties shall bear their own costs, fees and expenses, along with a pro rata share of the arbitrator's fees and expenses, and hereby waive the provisions of NRS 38.238.
Article 4: Revocation: This agreement may be revoked by written notice delivered to Physician within 30 days of signature and if not revoked will govern all medical services received by the patient.
Article 5: Severability Provision: In the event any provision(s) of this Agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed there from and the remainder of the Agreement enforced in accordance with Nevada and federal law.
Article 6: Condition of Treatment: I understand that signing this arbitration agreement is not a condition of **my** receiving medical treatment.

I understand that I have the right to receive a copy of this agreement.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ By: _____
Physician or Duly Authorized Representative (Date) Patient's Signature (Date)

By: Concierge Carpal Tunnel and Hand Surgery By: _____
Medical Group Name Print Patient's Name

CONCIERGE CARPAL TUNNEL and HAND SURGERY

PHARMACY INFORMATION FORM

This office utilizes e-prescribing, which allows your prescriptions to be sent electronically to your pharmacy for your convenience.

If you change your pharmacy in the future, please notify us immediately to avoid any delays in filling your prescriptions.

PATIENT NAME: _____

PATIENT DATE OF BIRTH: ____/____/_____

PHARMACY NAME: _____

PHARMACY ADDRESS OR CROSS STREETS: _____

PHARMACY PHONE: _____ PHARMACY FAX: _____

WE NEED YOUR PRIMARY DOCTOR'S

NAME: _____

_____

SIGNATURE (PATIENT OR RESPONSIBLE PARTY)