SPECIALIZED SURGEONS, INC.
THOMAS HIRAI, M.D.

Dear Patient:

Thank you for choosing our office and Thomas Hirai, M.D., as your healthcare provider. We are committed to your treatment being a successful experience. Please help us maintain accurate records by filling out forms legibly, and inform us of changes and updates to your account information (e.g., address, telephone number, medical insurance, etc.).

Please take note of the following policies and procedures of our medical practice, provide the information requested below, and sign your name where indicated. Thank you.

Communication Information

We normally communicate with our patients by letter, telephone, email and occasionally fax. It is important that we be provided with your accurate contact information. Additionally, you have the right to request that communications concerning your personal health information be made through confidential channels.

Specialized Surgeons, Inc. and Dr. Hirai will make reasonable efforts to accommodate your reasonable requests. Please provide your preferred methods of contact by completing the information below so that we can contact you to convey results from laboratory tests and treatment recommendations, and with payment information.

I request the use of the following communication methods for information related to my health, treatment, or payment. I authorize Specialized Surgeons, Inc. to communicate with me by unencrypted email except where applicable law requires otherwise.

Preferred Email Address: _____

Preferred Contact Telephone: (_____) _____-_____

Alternate Contact Telephone: (_____) _____-_____

_____ YES, you may leave messages on my voicemail

_____ NO, do not leave messages on my voicemail

If you are unavailable, Specialized Surgeons, Inc. has permission to speak with the following person(s):

_____

_____

Notice of Privacy Practices

I acknowledge that I was offered and/or received a copy of Specialized Surgeons, Inc.'s Notice of Privacy Practices. (A copy of the current Notice will be regularly posted in the reception area, and a copy of any amended Notice will be available at each appointment.)

_____
[Patient signature]

_____
[Print Name

_____
[Date of Birth]

Date: _____

Signature of Parent or Guardian (for minor patients):

_____
[Parent/Guardian signature]

_____
[Print Name

_____
[Minor's Date of Birth]

Date: _____

Patient Authorizations, Assignment of Benefits & Financial Policy

Patient Authorization

I authorize Specialized Surgeons, Inc. to conduct examinations, perform medically necessary procedures and administer treatment and medications that are deemed necessary or advisable.

Specialized Surgeons, Inc. is hereby authorized to release a report of services rendered, diagnosis, findings, and details of treatment for the purpose of receiving payment for services. Recipients may include authorized billing agents, insurance carriers and other third party payors, the Social Security Administration, Professional Review Organizations and other Intermediaries responsible for payment for services. This authorization may be revoked at any time by written notice to our office.

I agree to remain responsible for full payment of all charges not covered or denied by commercial insurance or Medicare, regardless of the reason for the failure of coverage or the denial.

Assignment of Benefits

I hereby assign to Specialized Surgeons, Inc. any insurance or other third party benefits available for healthcare services provided to me. I understand that Specialized Surgeons, Inc. has the right to accept or refuse assignment of such benefits. If assigned benefits are not paid to Specialized Surgeons, Inc., I agree to promptly forward to Specialized Surgeons, Inc. all health insurance and other third party payments that I receive for services rendered to me.

I understand that by my signature below I request that payment be made directly to Specialized Surgeons, Inc., and I authorize release of all medical information necessary to enable third party payors to pay the claim.

I authorize Specialized Surgeons, Inc. to use a photocopy of this assignment if necessary or convenient to facilitate payment, and I agree that any such photocopy may be used as if it were an original.

Patient Financial Policy

Copayments. Many insurance plans require patients to make a copayment at the time of service. If copayments are required under the terms of your insurance coverage, they will be due and owing at the time of your visit to our offices. Whenever a copayment is due, we reserve the right to decline to provide services unless/until the copayment is made. It is your responsibility to know and understand your insurance plan and the benefits are provided, and whether a copayment is due when you visit our offices. We accept all major credit cards, checks, and cash.

Primary Insurance. If you are covered by an insurance company that contracts with our office, we will bill your insurance company as a courtesy. If your insurance does not reimburse us within ninety (90) days, we will send you a statement and look to you for payment.

If you are unable to present an insurance card at the time of service, or if you are covered by an insurance company with which we are not contracted, we may require that you pay in full at the time of service. If we subsequently bill your insurance carrier and we are able to collect all amounts owed to us after you have fully paid your account, we will issue you a refund.

Multiple Insurance Carriers. Even if you are covered by more than one insurance carrier, our services might *not* be entirely reimbursed by your coverage. Typically, in such situations one insurer will be primary and the other secondary, and the secondary carrier will pay as a function of what your primary insurer pays. In some cases, the total may be less than 100%. We customarily bill your primary and secondary insurers as a courtesy; however, if there are any balances remaining after your insurers have processed our claims, you will be responsible for payment of all such balances.

Medicare. You are responsible for your annual deductible and 20% of the allowable fee for covered services. We will bill Medicare and any supplemental carrier you may have, once we have been informed that you have such coverage in effect. If any balance remains after your claims have been processed, we will send you a statement and look to you for payment..

Reminder for Medicare enrollees. If you are enrolled in a Medicare Advantage plan, you may need to first get a referral from your Primary Care Physician before your visit with us will be covered. Please call the number on your insurance card for more information.

Minor Patients. The adult(s) accompanying a minor and the minor's parents or guardians are responsible for full payment for services rendered. If a minor is unaccompanied, consent for treatment and payment arrangements must be provided in advance of treatment. Please contact our office for details.

Requests for Medical Records. We will honor all requests for copies of medical records in accordance with federal and California law. A signed release of records form is required at the time of each request. In accordance with Section 123110 of the California Health & Safety Code, we may charge you $0.25 cents per page copied, plus a one-time clerical fee of up to $25.00 per request. If you request that records be mailed to you, postage will be charged separately. If you have an unpaid outstanding balance at the time of your request, to the extent permitted by law we may choose not to release your medical records until our fees are paid in full.

Missed Appointments. If you cancel or reschedule an appointment with less than 24-hours advance notice, or if you fail to keep your appointment, we may charge you a $50.00 missed appointment fee. You are solely responsible for keeping your appointments and notifying us more than 24 hours in advance if you cannot keep an appointment, even if we contact you by telephone or email via an automated appointment reminder service.

Returned Check Fee. If your check is returned we may charge you up to $25.00 as a returned-check fee, to offset the fees imposed on our office by our own bank as well as the clerical time we will incur to address the issue. If your check is returned from the bank, we

reserve the right to refuse all additional checks as payment on your account. In such case, future payments will have to be made by cash, credit card or other acceptable form of electronic funds transfer.

Collections. If there is any remaining balance after your insurance carriers have paid our office, or if your insurers deny coverage, we will send you a statement showing any balance due and owing. All such statements will be due upon receipt. If payment is not made timely, we may charge simple interest at the rate of 10% annually on all outstanding balances more than 30 days old. If no payment is received after 120 days, your account may be turned over to a collection agency. A $25.00 collection processing fee will be added to your account to offset the administrative costs incurred when accounts are assigned for collection.

Credit Card on File. We reserve the right to require you to provide a credit card for payment of any remaining balance once your claim has been processed by your insurance company or Medicare. If we require a card, it will not be charged until the claim has been processed and we have received an Explanation of Benefits (EOB) detailing the amount of the charges that you are responsible for. You receive the same EOB directly from the insurance company or Medicare. Once the credit card is processed, you will receive a statement from us reflecting that payment. If we ask you for a credit card to be kept on file and you prefer not to provide one, we may ask you to pay for your services at the time of your visit.

I have read and understand the foregoing Patient Authorization, Assignment of Benefits and Financial Policy, and by consenting to treatment from Specialized Surgeons, Inc., I agree to be bound by the foregoing.

_____
[Patient signature]

_____
[Print Name

_____
[Date of Birth]

Date: _____

Signature of Parent or Guardian (for minor patients):

_____
[Parent/Guardian signature]

_____
[Print Name

_____
[Minor's Date of Birth]

Date: _____