Dr. Darius E. Lin
22 Odessey Suite 270B
Irvine CA 92618
949-431-2668

RECEIPT OF NOTICE OF PRIVACY PRACTICE

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April,15 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPAA:
Or to file a complaint:
The U.S Department of Health &
Human Services Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C, 20201
202-619-0257
Toll Free: 877-696-6775

Please contact us for more information:
Darius E. Lin, Inc.
Irvine Orthopedics
22 Odyssey Suite 270B
Irvine, CA 92618
949-431-2668

I have received a copy of the Notice of Privacy Practices for Darius E. Lin, Inc. Irvine Orthopedics, as required by the Health Insurance Portability & Accountability Act (HIPAA) of 1996. I understand that this organization reserves the right to modify the Privacy Practices outlined in this notice

______________________________ ______________
Ptient/Guardian signature Date

______________________________ ______________
Witness or Office Personnel Date

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CONSENT & ASSIGNMENT OF BENEFITS

INFORMED CONSENT: I consent to the use or disclosure of my health information for the purpose of treatment, payment, and health care operations, including any insurance company, adjustor, or attorney involved in this case. I also hereby authorize the release of all information to other physicians and insurance carriers upon request for the purpose of payment for medical services and further treatment of care by another physician. I hereby acknowledge that I have read, understand and agree to hereby give consent to access, treat and test.

ASSIGNMENT OF BENEFITS: I hereby instruct and direct my insurance company to pay by check made out and mailed to Darius E. Lin, Inc. and its affiliated Physicians. I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

A photocopy of this consent document shall be considered as effective and valid as the original.

______________________________ ______________

Ptient/Guardian signature Date

______________________________ ______________

Witness or Office Personnel Date

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WAIVER FORM

Eligibility of coverage for treatment has not been verified. However, I wish to receive medical treatment at this time.

I understand that if it is determined that I am not eligible for coverage I will be responsible for all charges that may occur for services provided.

I understand you will submit my claims to my insurance company however if you do not receive payment after two attempts, I will be responsible for the balance. I understand that you will supply the necessary paperwork for me to submit my claim to my insurance company so I will be reimbursed for the services rendered. (This does not apply to Medicare patients)

Some insurance companies will only pay for services that it determines to be “reasonable and necessary”. Your insurance company may determine that a particular service, although it would be otherwise covered, is not “reasonable and necessary” and your insurance will deny payment for that service. Some insurance companies have notified our office certain procedures are <u>non-covered</u> or <u>investigational</u> according to their policies and therefore deny payment.

I, the undersigned, acknowledge that my physician has informed me that the processing of my claim by my insurance carrier is not a guarantee of payment; therefore, if my claim is denied by my insurance, I agree to be personally and fully responsible for payment to Darius E. Lin, Inc. Irvine Orthopedics. This waiver does not have an expiration date.

____________________________________ ____________
Ptient/Guardian signature Date

____________________________________ ____________
Witness or Office Personnel Date

IRVINE ORTHOPEDICS
Empowering Motion

Dr. Darius E. Lin
22 Odessey Suite 270B
Irvine CA 92618
949-431-2668

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 California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are 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 arbitration.

Article 2: All Claims Must Be Arbitrated: It is the intention of the parties that this agreement shall cover all 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 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 a neutral arbitrator who was previously a California superior court judge, to preside over the matter. Both parties shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. Patient shall pursue his/her claims with reasonable diligence, and the arbitration shall be governed pursuant to Code of Civil Procedure §§ 1280-1295 and the Federal Arbitration Act (9 U.S.C. §§ 1-4). The parties shall bear their own costs, fees and expenses, along with a pro rata share of the neutral arbitrator's fees and expenses.

Article 4: Retroactive Effect: The patient intends this agreement to cover all services rendered by Physician not only after the date it is signed (including, but not limited to, emergency treatment), but also before it was signed as well.

Article 5: **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 6: Severability Provision: In the event any provision(s) of this Agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed therefrom and the remainder of the Agreement enforced in accordance with California law.

I understand that I have the right to receive a copy of this agreement. By my signature below, I acknowledge that I have received a copy.

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: ___________________________________** _____/_____/_____

PHYSICIANS'S OF DUTY AUTHORIZED RESPRESENTATIVE SIGNATURE **DATE** **PATIENT'S SIGNATURE** **DATE**

____
PATIENT'S PRINT NAME

BY: ____
PRINT OR STAMP NAME OF PHYSICIAN, MEDICAL GROUP OR ASSOCIATE NAME

BY: ____
PATIENT'S REPRESENTATIVE'S SIGNATURE

BY: ____
SIGNATURE OF TRANSLATOR (IF APPLICABLE)

____
PRINT NAME AND RELATIONSHIP TO PATIENT

____
PRINT NAME OF TRANSLATOR

A signed copy of this document should be given to the patient. The original copy will be archived in the patient's medical file.