INFORMED CONSENT

Medical Doctors, Chiropractic Doctors, and Physical Therapist's that perform manipulation are required by law to obtain your informed consent before starting treatment.

I _____, Do hereby give my consent to the performance of conservative non-invasive treatment to the Joints and Soft Tissues. I understand that the procedures may consist of manipulation/adjustments involving movement of the joints and soft tissues. Physical Therapy and exercises may also be used. Although extremity and spinal manipulation/adjustments is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

Soreness/Bruising: I am aware that like exercise it is common to experience muscle soreness and occasionally bruising in the first few treatments.
Dizziness: Temporary Symptoms like dizziness and nausea can occur but are relative rare.
Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities, or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disc, or other abnormality is detected, this office will proceed with extra caution.
Physical Therapy Burns: Some of the therapies used in this office generate heat and rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase in pain and possible blistering. This should be reported to the Doctor. Tests have been or will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

Treatment Results
I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarentee has been made to me regarding the outcome of these procedures. I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

I have read or had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction. I have made my decision voluntarily and freely.

Sign Below

Signature of Patient _____Date_____

Signature of Parent or Guardian (if a minor)_____Date_____

Signature of Witness_____Date_____

Assignment of Benefits:

Your signature is necessary for us to process any insurance claims and to ensure payment of services rendered. I authorize release of all medical information necessary to process my insurance, workman's compensation or personal injury claims or that is pertinent to my medical care. I assign all medical benefits to which I am entitled to the above named physician or clinic. This agreement will remain in effect until all money owed to the above named physician or clinic is paid in full.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ THIS INFORMATION AND UNDERSTAND IT.

Patient or Responsible Party Signature:_____Date:_____

Contracted Insurances:

If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a co-pay or deductible, you must pay that at the time of service. It is the insurance company that makes the final determination of your eligibility. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment or denial of payment from the insurance company. You are responsible for all charges not paid by your insurance company.

Non-contracted Insurances:

Insurance is a contract between you and your insurance company. We are NOT a party to this contract. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You are responsible to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company.

Payment if you have no insurance:

Full payment is due at the time of service; Cash discounted Initial evaluation with treatment $100.00; all following visits $65.00. For Students the rate for an Initial evaluation with treatment $80.00; all following visits $55.00. Massage Therapy: $85.00 per full hour and $45.00

FINANCIAL AGREEMENT

I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. As a courtesy, my insurance company will be billed. I agree to pay in a current manner and, in accordance with the terms and conditions of Xcelerate Sports Therapy and Chiropractic, any balance to said professional fees over and above third party reimbursement, including deductibles, co-payments, exclusions or denials. I understand that if treatment is suspended or terminated, any fees for professional services rendered will be due and payable upon request. I understand that any payment which is delinquent (following 30 days from the request), may result in a 1.5% per month assessment on the remaining balance and that I will be fully responsible for any legal/collection or attorney fees, if it becomes necessary to resolve the outstanding balance. A service charge of $50 may be assessed for all no shows and $25 for cancellations within a 24-hour period.

PATIENT HEALTH INSURANCE POLICY

As a courtesy only, we will verify your Health Insurance benefits, however it is your responsibility to be knowledgeable of your physical therapy benefits, co-pays, deductibles, denials, and exclusions.

I have read and understand this policy_____Date_____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPPA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPPA" provides penalties for cover
ed entities that misuse personal health information.

As required by "HIPPA", we have prepared this explanation of how we are required to maintain the privacy of your health information.

We may use and disclose your health information. We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health careproviders. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collectionactivities, and utilization review. An example of this would be sending a bill for your visit to your insurance companyfor payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessmentand improvement activities, auditing functions, cost-management analysis, and customer service. An example would bean internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.
We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions on relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are however, not required to agree to requested restriction.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by to maintain the privacy of your protected health information and to provide you with notice of our legalduties and privacy practices with respect to protected health information. This notice is effective as of April 14, 2003 and we arerequired 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 wemaintain. We will post and you may request a written copy of a revised Notice Privacy Practices from this office. You haverecourse if you feel that your privacy protections have been violated. You have the right to file written complaint with ouroffice, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of thisnotice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.
Please contact us for more information:

For more information about HIPPA
or to file a complaint:
The U.S. Department of Health & Human Services
Office of Civil Rights200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775