HIPAA PRIVACY NOTICE

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

INTRODUCTION

WE ARE REQUIRED BY LAW TO MAINTAIN THE PRIVACY OF "PROTECTED HEALTH INFORMATION." "PROTECTED HEALTH INFORMATION" INCLUDES ANY IDENTIFIABLE INFORMATION THAT WE OBTAIN FROM YOU OR OTHERS THAT RELATES TO YOUR PHYSICAL OR MENTAL HEALTH, THE HEALTH CARE YOU HAVE RECEIVED, OR PAYMENT FOR YOUR HEALTH CARE. AS REQUIRED BY LAW, THIS NOTICE PROVIDES YOU WITH INFORMATION ABOUT YOUR RIGHTS AND OUR LEGAL DUTIES AND PRIVACY PRACTICES WITH RESPECT TO THE PRIVACY OF PROTECTED HEALTH INFORMATION. THIS NOTICE ALSO DISCUSSES THE USES AND DISCLOSURES WE WILL MAKE OF YOUR PROTECTED HEALTH INFORMATION. WE MUST COMPLY WITH THE PROVISIONS OF THIS NOTICE, ALTHOUGH WE RESERVE THE RIGHT TO CHANGE THE TERMS OF THIS NOTICE FROM TIME TO TIME AND TO MAKE THE REVISED NOTICE EFFECTIVE FOR ALL PROTECTED HEALTH INFORMATION WE MAINTAIN. YOU CAN ALWAYS
REQUEST A COPY OF OUR MOST CURRENT PRIVACY NOTICE FROM OUR OFFICE.

PERMITTED USES AND DISCLOSURES

WE CAN USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

♦ TREATMENT MEANS THE PROVISION, COORDINATION OR MANAGEMENT OF YOUR HEALTH CARE, INCLUDING CONSULTATIONS BETWEEN HEALTH CARE PROVIDERS REGARDING YOUR CARE AND REFERRALS FOR HEALTH CARE FROM ONE HEALTH CARE PROVIDER TO ANOTHER. FOR EXAMPLE, A DOCTOR TREATING YOU FOR A BROKEN LEG MAY NEED TO KNOW IF YOU HAVE DIABETES BECAUSE DIABETES MAY SLOW THE HEALING PROCESS. THEREFORE, THE DOCTOR MAY REVIEW YOUR MEDICAL RECORDS TO ASSESS WHETHER YOU HAVE POTENTIALLY COMPLICATING CONDITIONS LIKE DIABETES.

♦ PAYMENT MEANS ACTIVITIES WE UNDERTAKE TO OBTAIN REIMBURSEMENT FOR THE HEALTH CARE PROVIDED TO YOU, INCLUDING DETERMINATIONS OF ELIGIBILITY AND COVERAGE AND OTHER UTILIZATION REVIEW ACTIVITIES. FOR EXAMPLE, PRIOR TO PROVIDING HEALTH CARE SERVICES, WE MAY NEED TO PROVIDE TO YOUR INSURANCE CARRIER (OR OTHER THIRD PARTY PAYOR) INFORMATION ABOUT YOUR MEDICAL CONDITION TO DETERMINE WHETHER THE PROPOSED COURSE OF TREATMENT WILL BE COVERED. WHEN WE SUBSEQUENTLY BILL THE CARRIER OR OTHER THIRD PARTY PAYOR FOR THE SERVICES RENDERED TO YOU, WE CAN PROVIDE THE CARRIER OR OTHER THIRD PARTY PAYOR WITH INFORMATION REGARDING YOUR CARE IF NECESSARY TO OBTAIN
PAYMENT.

♦ HEALTH CARE OPERATIONS MEAN THE SUPPORT FUNCTIONS OF OUR PRACTICE RELATED TO TREATMENT AND PAYMENT, SUCH AS QUALITY ASSURANCE ACTIVITIES, CASE MANAGEMENT, RECEIVING AND RESPONDING TO PATIENT COMPLAINTS, PHYSICIAN REVIEWS, COMPLIANCE PROGRAMS, AUDITS, BUSINESS PLANNING, DEVELOPMENT, MANAGEMENT AND ADMINISTRATIVE ACTIVITIES. FOR EXAMPLE, WE MAY USE YOUR MEDICAL INFORMATION TO EVALUATE THE PERFORMANCE OF OUR STAFF IN CARING FOR YOU. WE MAY ALSO COMBINE MEDICAL INFORMATION ABOUT MANY PATIENTS TO
DECIDE WHAT SERVICES ARE NOT NEEDED, AND WHETHER CERTAIN NEW TREATMENTS ARE EFFECTIVE. DISCLOSURES RELATED TO COMMUNICATIONS WITH YOU OR YOUR FAMILY

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 OR RELATE SPECIFICALLY TO YOUR MEDICAL CARE THROUGH OUR OFFICE. FOR EXAMPLE, WE MAY LEAVE APPOINTMENT REMINDERS ON YOUR ANSWERING MACHINE OR WITH A FAMILY MEMBER OR OTHER PERSON WHO MAY ANSWER THE TELEPHONE AT THE NUMBER THAT YOU HAVE GIVEN US IN ORDER TO CONTACT YOU. WE MAY DISCLOSE YOUR PROTECTED HEALTH INFORMATION TO YOUR FAMILY OR FRIENDS OR ANY OTHER INDIVIDUAL IDENTIFIED BY YOU WHEN THEY ARE INVOLVED IN YOUR CARE OR THE PAYMENT FOR YOUR CARE. WE WILL ONLY DISCLOSE THE PROTECTED HEALTH INFORMATION DIRECTLY RELEVANT TO THEIR INVOLVEMENT IN YOUR CARE OR PAYMENT. WE MAY ALSO USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION TO NOTIFY, OR ASSIST IN THE NOTIFICATION OF, A FAMILY MEMBER, A PERSONAL REPRESENTATIVE, OR ANOTHER PERSON RESPONSIBLE FOR YOUR CARE OF YOUR LOCATION, GENERAL CONDITION OR DEATH. IF YOU ARE AVAILABLE, WE WILL GIVE YOU AN OPPORTUNITY TO OBJECT TO THESE DISCLOSURES, AND WE WILL NOT MAKE THESE DISCLOSURES IF YOU OBJECT. IF YOU ARE NOT AVAILABLE, WE WILL DETERMINE WHETHER A DISCLOSURE TO YOUR FAMILY OR FRIENDS IS IN YOUR BEST INTEREST, AND WE WILL DISCLOSE ONLY THE PROTECTED HEALTH INFORMATION THAT IS DIRECTLY RELEVANT TO THEIR INVOLVEMENT IN YOUR CARE. WE WILL ALLOW YOUR FAMILY AND FRIENDS TO ACT ON YOUR BEHALF TO PICK UP PRESCRIPTIONS, MEDICAL SUPPLIES, X-RAYS, AND SIMILAR FORMS OF
PROTECTED HEALTH INFORMATION, WHEN WE DETERMINE, IN OUR PROFESSIONAL JUDGMENT, THAT IT IS IN YOUR BEST INTEREST TO MAKE SUCH DISCLOSURES.

OTHER SITUATIONS

ORGAN AND TISSUE DONATION. IF YOU ARE AN ORGAN DONOR, WE MAY RELEASE MEDICAL INFORMATION TO ORGANIZATIONS THAT HANDLE ORGAN PROCUREMENT OR ORGAN, EYE OR TISSUE TRANSPLANTATION OR TO AN ORGAN DONATION BANK, AS NECESSARY TO FACILITATE ORGAN OR TISSUE DONATION AND TRANSPLANTATION.

MILITARY AND VETERANS. IF YOU ARE A MEMBER OF THE ARMED FORCES, WE MAY RELEASE MEDICAL INFORMATION ABOUT YOU AS REQUIRED BY MILITARY COMMAND AUTHORITIES. WE MAY ALSO RELEASE MEDICAL INFORMATION ABOUT FOREIGN MILITARY PERSONNEL TO THE APPROPRIATE FOREIGN MILITARY AUTHORITY.

PUBLIC HEALTH RISKS. WE MAY DISCLOSE MEDICAL INFORMATION ABOUT YOU FOR PUBLIC HEALTH ACTIVITIES. THESE ACTIVITIES GENERALLY INCLUDE THE FOLLOWING:

♦ TO PREVENT OR CONTROL DISEASE, INJURY OR DISABILITY
♦ TO REPORT BIRTHS AND DEATHS
♦ TO REPORT VICTIM OF ABUSE, NEGLECT, OR DOMESTIC VIOLENCE
♦ TO REPORT REACTIONS TO MEDICATIONS
♦ TO NOTIFY PEOPLE OF PRODUCT, RECALLS, REPAIRS OR REPLACEMENTS
♦ TO NOTIFY A PERSON WHO MAY HAVE BEEN EXPOSED TO A DISEASE OR MAY BE AT RISK FOR CONTRACTING OR SPREADING A DISEASE OR CONDITION HEALTH OVERSIGHT ACTIVITIES. WE MAY DISCLOSE MEDICAL INFORMATION TO FEDERAL OR STATE AGENCIES THAT OVERSEE OUR ACTIVITIES. THESE ACTIVITIES ARE NECESSARY FOR THE GOVERNMENT TO MONITOR THE HEALTH CARE SYSTEM, GOVERNMENT PROGRAMS, AND COMPLIANCE WITH CIVIL RIGHTS LAWS. WE MAY DISCLOSE PROTECTED HEALTH INFORMATION TO PERSONS UNDER THE FOOD AND DRUG ADMINISTRATION'S JURISDICTION TO TRACK PRODUCTS OR TO CONDUCT POST-MARKETING SURVEILLANCE.

LAWSUITS AND DISPUTES. IF YOU ARE INVOLVED IN A LAWSUIT OR DISPUTE, WE MAY DISCLOSE MEDICAL INFORMATION ABOUT YOU IN RESPONSE TO A COURT OR ADMINISTRATIVE ORDER. WE MAY ALSO DISCLOSE MEDICAL INFORMATION ABOUT YOU IN A RESPONSE TO A SUBPOENA, DISCOVERY REQUEST OR OTHER LAWFUL PROCESS BY SOMEONE ELSE INVOLVED IN THE DISPUTE.

LAW ENFORCEMENT. WE MAY RELEASE MEDICAL INFORMATION IF ASKED TO DO SO BY A LAW ENFORCEMENT OFFICIAL:

♦ IN RESPONSE TO A COURT ORDER, SUBPOENA, WARRANT, SUMMONS OR SIMILAR PROCESS
♦ TO IDENTIFY OR LOCATE A SUSPECT, FUGITIVE, MATERIAL WITNESS, OR MISSING PERSON
♦ ABOUT THE VICTIM OF A CRIME IF, UNDER CERTAIN LIMITED CIRCUMSTANCES, WE ARE UNABLE TO OBTAIN THE PERSON'S AGREEMENT
♦ ABOUT A DEATH WE BELIEVE MAY BE THE RESULT OF A CRIMINAL CONDUCT
♦ ABOUT CRIMINAL CONDUCT ON OUR PREMISES
♦ IN EMERGENCY CIRCUMSTANCES TO REPORT A CRIME; THE LOCATION OF THE CRIME OR VICTIMS OR THE IDENTITY, DESCRIPTION OR LOCATION OF THE PERSON WHO COMMITTED THE CRIME

CORONERS, MEDICAL EXAMINERS AND FUNERAL DIRECTORS. WE MAY RELEASE MEDICAL INFORMATION TO A CORONER OR MEDICAL EXAMINER. THIS MAY BE NECESSARY, FOR EXAMPLE, TO IDENTIFY A DECEASED PERSON OR DETERMINE THE CAUSE OF DEATH. WE MAY ALSO RELEASE MEDICAL INFORMATION ABOUT PATIENTS TO FUNERAL DIRECTORS AS NECESSARY TO CARRY OUT THEIR DUTIES.

INMATES. IF YOU ARE AN INMATE OF A CORRECTIONAL INSTITUTION OR UNDER THE CUSTODY OF A LAW ENFORCEMENT OFFICIAL, WE MAY RELEASE MEDICAL INFORMATION ABOUT YOU TO THE CORRECTIONAL INSTITUTION OR LAW ENFORCEMENT OFFICIAL. THIS RELEASE WOULD BE NECESSARY FOR THE INSTITUTION TO PROVIDE YOU WITH HEALTH CARE, TO PROTECT YOUR HEALTH AND SAFETY OR THE HEALTH AND SAFETY OF OTHERS, OR FOR THE SAFETY AND SECURITY OF THE CORRECTIONAL INSTITUTION.

SERIOUS THREATS. AS PERMITTED BY APPLICABLE LAW AND STANDARDS OF ETHICAL CONDUCT, WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION IF WE, IN GOOD FAITH, BELIEVE THAT THE USE OF DISCLOSURE IS NECESSARY TO PREVENT OR LESSEN A SERIOUS AND IMMINENT THREAT TO THE HEALTH OR SAFETY OF A PERSON OR THE PUBLIC.

DISASTER RELIEF. WHEN PERMITTED BY LAW, WE MAY COORDINATE OUR USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION WITH PUBLIC OR PRIVATE ENTITIES AUTHORIZED BY LAW OR BY CHARTER TO ASSIST IN DISASTER RELIEF EFFORTS.

YOUR RIGHTS

1. YOU HAVE THE RIGHT TO REQUEST RESTRICTIONS ON OUR USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS. HOWEVER, WE ARE NOT REQUIRED TO AGREE TO YOUR REQUEST.

2. YOU HAVE THE RIGHT TO REASONABLY REQUEST TO RECEIVE COMMUNICATIONS OF PROTECTED HEALTH INFORMATION BY ALTERNATIVE MEANS OR AT ALTERNATIVE LOCATIONS. 3. SUBJECT TO PAYMENT OF A REASONABLE COPYING CHARGE AS PROVIDED BY STATE LAW, YOU HAVE THE RIGHT TO INSPECT OR OBTAIN A COPY OF THE PROTECTED HEALTH INFORMATION CONTAINED IN YOUR MEDICAL AND BILLING RECORDS AND IN ANY OTHER PRACTICE RECORDS USED BY US TO MAKE DECISIONS ABOUT YOU, EXCEPT FOR:

♦ PSYCHOTHERAPY NOTES, WHICH ARE NOTES RECORDED BY A MENTAL HEALTH PROFESSIONAL DOCUMENTING OR ANALYZING THE CONTENTS OF CONVERSATION DURING A PRIVATE COUNSELING SESSION OR A GROUP, JOINT OR FAMILY COUNSELING SESSION AND THAT HAVE BEEN SEPARATED FROM THE REST OF YOUR MEDICAL RECORD
♦ INFORMATION COMPILED IN A REASONABLE ANTICIPATION OF, OR FOR USE IN, A CIVIL, CRIMINAL, OR ADMINISTRATIVE ACTION OR PROCEEDING.
♦ PROTECTED HEALTH INFORMATION INVOLVING LABORATORY TESTS WHEN YOUR ACCESS IS REQUIRED BY LAW
♦ IF YOU ARE A PRISON INMATE AND OBTAINING SUCH INFORMATION WOULD JEOPARDIZE YOUR HEALTH, SAFETY, SECURITY, CUSTODY, OR REHABILITATION OR THAT OF OTHER INMATES, OR THE SAFETY OF

ANY OFFICER, EMPLOYEE, OR OTHER PERSON AT THE CORRECTIONAL INSTITUTION OR PERSON RESPONSIBLE FOR TRANSPORTING YOU

- IF WE OBTAINED OR CREATED PROTECTED HEALTH INFORMATION AS PART OF A RESEARCH STUDY FOR AS LONG AS THE RESEARCH IS IN PROGRESS, PROVIDED THAT YOU AGREED TO THE TEMPORARY DENIAL OF ACCESS WHEN CONSENTING TO PARTICIPATE IN THE RESEARCH
- YOUR PROTECTED HEALTH INFORMATION IS CONTAINED IN RECORDS KEPT BY A FEDERAL AGENCY OR CONTRACTOR WHEN YOUR ACCESS IS REQUIRED BY LAW
- IF THE PROTECTED HEALTH INFORMATION WAS OBTAINED FROM SOMEONE OTHER THAN US UNDER A PROMISE OF CONFIDENTIALITY AND THE ACCESS REQUESTED WOULD BE REASONABLY LIKELY TO REVEAL THE SOURCE OF THE INFORMATION

WE MAY ALSO DENY A REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION IF:

- A LICENSED HEALTH CARE PROFESSIONAL HAS DETERMINED, IN THE EXERCISE OF PROFESSIONAL JUDGMENT, THAT THE ACCESS REQUESTED IS REASONABLY LIKELY TO ENDANGER YOUR LIFE OR PHYSICAL SAFETY OR THAT OF ANOTHER PERSON
- THE PROTECTED HEALTH INFORMATION MAKES REFERENCE TO ANOTHER PERSON (UNLESS SUCH OTHER PERSON IS A HEALTH CARE PROVIDER) AND A LICENSED HEALTH CARE PROFESSIONAL HAS DETERMINED, IN THE EXERCISE OF PROFESSIONAL JUDGMENT, THAT THE ACCESS REQUESTED IS REASONABLY LIKELY TO CAUSE SUBSTANTIAL HARM TO SUCH OTHER PERSON
- THE REQUEST FOR ACCESS IS MADE BY THE INDIVIDUAL'S PERSONAL REPRESENTATIVE AND A LICENSED HEALTH CARE PROFESSIONAL HAS DETERMINED, IN THE EXERCISE OF PROFESSIONAL JUDGMENT, THAT THE PROVISION OF ACCESS TO SUCH PERSONAL REPRESENTATIVE IS REASONABLY LIKELY TO CAUSE SUBSTANTIAL HARM TO YOU OR ANOTHER PERSON

IF WE DENY A REQUEST FOR ACCESS FOR ANY OF THE THREE REASONS DESCRIBED ABOVE, THEN YOU HAVE THE RIGHT TO HAVE OUR DENIAL REVIEWED IN ACCORDANCE WITH THE REQUIREMENTS OF APPLICABLE LAW.

4. YOU HAVE THE RIGHT TO REQUEST A CORRECTION TO YOUR PROTECTED HEALTH INFORMATION, BUT WE MAY DENY YOUR REQUEST FOR CORRECTION, IF WE DETERMINE THAT THE PROTECTED HEALTH INFORMATION OR RECORD THAT IS THE SUBJECT OF THE REQUEST:

- WAS NOT CREATED BY US, UNLESS YOU PROVIDE A REASONABLE BASIS TO BELIEVE THAT THE ORIGINATOR OF PROTECTED HEALTH INFORMATION IS NO LONGER AVAILABLE TO ACT ON THE REQUESTED AMENDMENT
- IS NOT PART OF YOUR MEDICAL OR BILLING RECORDS
- IS NOT AVAILABLE FOR INSPECTION AS SET FORTH ABOVE
- IS NOT ACCURATE AND COMPLETE

IN ANY EVENT, ANY AGREED UPON CORRECTION WILL BE INCLUDED AS AN ADDITION TO, AND NOT A REPLACEMENT OF, ALREADY EXISTING RECORDS.

5. YOU HAVE THE RIGHT TO RECEIVE AN ACCOUNTING OF DISCLOSURES OF PROTECTED HEALTH INFORMATION MADE BY US TO INDIVIDUALS OR ENTITIES OTHER THAN TO YOU FOR THE PERIOD PROVIDED BY LAW, EXCEPT FOR DISCLOSURES:

- TO CARRY OUT TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS AS PROVIDED ABOVE
- TO PERSONS INVOLVED IN YOUR CARE OR FOR OTHER NOTIFICATION PURPOSES AS PROVIDED BY LAW
- FOR NATIONAL SECURITY OR INTELLIGENCE PURPOSES AS PROVIDED BY LAW
- TO CORRECTIONAL INSTITUTIONS OR LAW ENFORCEMENT OFFICIALS AS PROVIDED BY LAW
- THAT OCCURRED PRIOR TO APRIL 14, 2003
- THAT ARE OTHERWISE NOT REQUIRED BY LAW TO BE INCLUDED IN THE ACCOUNTING

6. YOU HAVE THE RIGHT TO REQUEST AND RECEIVE A PAPER COPY OF THIS NOTICE FROM US.
7. THE ABOVE RIGHTS MAY BE EXERCISED ONLY BY WRITTEN COMMUNICATION TO US. ANY REVOCATION OR OTHER MODIFICATION OF CONSENT MUST BE IN WRITING DELIVERED TO US. COMPLAINTS

IF YOU BELIEVE THAT YOUR PRIVACY RIGHTS HAVE BEEN VIOLATED, YOU SHOULD IMMEDIATELY CONTACT OUR PRACTICE OR OUR PRIVACY OFFICER. ALL COMPLAINTS MUST BE SUBMITTED IN WRITING. WE WILL NOT TAKE ACTION AGAINST YOU FOR FILING A COMPLAINT. YOU ALSO MAY FILE A COMPLAINT WITH THE SECRETARY OF HEALTH AND HUMAN SERVICES.

INFORMED CONSENT

I UNDERSTAND THAT THIS FACILITY, ITS DOCTORS & STAFF ARE ACCEPTING MY CASE BASED UPON EXAMINATION FINDINGS & BELIEVE THE OUTLINED TREATMENT SHOULD PRODUCE CHANGE AND/OR IMPROVEMENT. HOWEVER, AS WITH ANY DIAGNOSTIC TEST, PROCEDURE, EXAMINATION, OR DOCTOR'S CARE A GUARANTEE OF IMPROVEMENT OR COMPLETE RECOVERY CANNOT BE MADE AND IT IS EVEN POSSIBLE THAT NO CHANGE WILL OCCUR. I FURTHER UNDERSTAND THAT IN THE PRACTICE OF HEALTH CARE THERE ARE SOME RISKS INCLUDING, BUT NOT LIMITED TO, FRACTURE, DISK INJURIES, STROKES, DISLOCATIONS, SPRAINS/STRAINS, DRUG INTERACTIONS, AND/OR OTHER INJURIES OR SIDE EFFECTS WHICH CANNOT BE PREDICTED. I DO NOT EXPECT THE PROVIDER TO BE ABLE TO ANTICIPATE AND EXPLAIN ALL RISKS AND/OR COMPLICATIONS, AND I WISH TO RELY ON THE PROVIDER TO EXERCISE JUDGMENT DURING THE COURSE OF THE PROCEDURE(S) WHICH THE PROVIDER FEELS AT THE TIME IS IN MY BEST INTEREST. PATIENTS HAVE THE RIGHT TO REFUSE TREATMENT, BUT MUST BE AWARE OF THE PROBABLE CONSEQUENCES OF REFUSING TREATMENT AND/OR FAILING TO COOPERATE WITH PRESCRIBED TREATMENT. SHOULD YOU REFUSE AND/OR FAIL TO COMPLY WITH RECOMMENDATIONS YOUR PROVIDER WILL DISCUSS SPECIFIC CONSEQUENCES WITH YOU. THEREFORE I GIVE MY FULL CONSENT TO THE PROVIDER TO RENDER TREATMENT ON ME OR THE MINOR FOR WHOM I AM LEGALLY RESPONSIBLE BY A HEALTH CARE PROVIDER OF THIS FACILITY.

ASSIGNMENT OF BENEFITS/AUTHORIZATION & LIEN

I, THE ASSIGNEE, BEING THE PATIENT OR LEGAL GUARDIAN FOR SAID MINOR LISTED BELOW, DO HEREBY IRREVOCABLY AUTHORIZE, DIRECT, ASSIGN AND GIVE FULL LIEN TO THE OFFICE NAMED ABOVE AND LISTED BELOW, HEREINAFTER REFERRED TO AS THE "FACILITY" AGAINST ANY & ALL INSURANCE BENEFITS, PROCEEDS OF ANY SETTLEMENT, JUDGMENT OR VERDICT WHICH MAY BE PAID TO THE UNDERSIGNED AS A RESULT OF THE INJURIES OR ILLNESS FOR WHICH I HAVE BEEN TREATED BY THE FACILITY. I, THE ASSIGNEE, FURTHER AUTHORIZE ANY AND ALL INSURANCE COMPANY, ATTORNEY AND ANY & ALL THIRD PARTY PAYER TO PAY DIRECTLY TO THE FACILITY ALL SUMS OF MONEY DUE THEM FOR ANY & ALL SERVICES RENDERED TO ME OR MINOR BY WHOM I AM RESPONSIBLE FOR BY REASON OF ACCIDENT, ILLNESS OR BY ANY & ALL REASON OF ANY OTHER BILLS THAT ARE DUE OR MAY BECOME DUE, AND TO WITHHOLD SUCH SUMS FROM ANY HEALTH & ACCIDENT, WORKERS COMPENSATION AND/OR INCLUDING ALL INSURANCE OR THIRD PARTY BENEFITS. ASSIGNEE AGREES THAT THIS FACILITY & STAFF MAY DELIVER MEDICAL RECORDS, CONSULTATIONS, DEPOSITIONS, AND/OR COURT APPEARANCES WHICH MUST BE PAID IN FULL IN ADVANCE AND AUTHORIZES THIS FACILITY TO RELEASE ANY INFORMATION PERTINENT TO SAID HEALTH CARE TO ANY INSURANCE COMPANY, ADJUSTER, ATTORNEY, OR LEGAL SERVICE BUREAU TO FACILITATE COLLECTIONS UNDER THE TERMS OF THIS DOCUMENT. ASSIGNEE GRANTS THE FACILITY A FULL POWER OF ATTORNEY TO ENDORSE AND/OR SIGN MY NAME ON ANY & ALL CHECKS FOR PAYMENT OF ANY INDEBTEDNESS OWED THIS OFFICE & ASSIGNEE.

PAYMENT TERMS & CONDITIONS

AS A COURTESY, COLLINS CHIROPRACTIC & DIAGNOSTICS WILL OBTAIN A VERIFICATION OF APPLICABLE INSURANCE BENEFITS AS THEY ARE QUOTED TO US, BUT SOME THIRDS PARTY PAYERS MISQUOTE BENEFITS, COVERAGE, AND LIABILITY. OUR STAFF IS NOT RESPONSIBLE FOR WHAT A THIRD PARTY PAYER OR REPRESENTATIVE MAY SAY. ANY CONTRACTUAL, WRITTEN, VERBAL OR OTHER OBLIGATIONS OR ARRANGEMENTS BETWEEN YOU AND AN ATTORNEY, INSURANCE COMPANY, LIABLE OR THIRD PARTY ARE BETWEEN YOU AND SAID PERSON. OUR FACILITY WILL FILE INITIAL INSURANCE CLAIMS FOR YOU. SECONDARY CLAIM SUBMISSION AND/OR ADDITIONAL REPORTS OR DOCUMENTS SENT FOR YOUR BENEFIT MAY RESULT IN ADDITIONAL CHARGES, FOR WHICH YOU ARE RESPONSIBLE. COPAYS, DEDUCTIBLES, AND ALL NON-COVERED SERVICE CHARGES ARE DUE AT THE TIME OF SERVICE. PATIENTS ARE RESPONSIBLE FOR CHARGES ON ALL SERVICES AND/OR PRODUCTS WHICH MAY EXCEED THE MAXIMUM ALLOWABLE AND/OR WHEN A THIRD PARTY OR INSURANCE CARRIER DOES NOT REIMBURSE THE FACILITY APPROPRIATELY. ALL ACCOUNT BALANCES MUST BE PAID IN FULL WITHIN 90 DAYS OF TREATMENT. PATIENTS ARE FULLY RESPONSIBLE FOR ALL MONEY OWED THIS OFFICE AND SUCH PAYMENT IS NOT CONTINGENT ON ANY SETTLEMENT, CLAIM, JUDGMENT, OR VERDICT BY WHICH THEY MAY EVENTUALLY RECOVER SAID FEE AND IT IS ALSO REGARDLESS OF ANY ATTORNEY LIENS OR PENDING SETTLEMENTS. IF A THIRD PARTY PAYER FAILS TO PAY SAID BALANCE IN FULL WITHIN 90 DAYS, THE PATIENT MUST PAY THE BALANCE IN FULL. ASSIGNEE IS FULLY RESPONSIBLE FOR ALL MONEY OWED THIS FACILITY FOR ANY AND ALL TREATMENT, PRODUCTS & SERVICES THE DAY THEY ARE RENDERED. PATIENTS ARE ELIGIBLE FOR A MAXIMUM $250 PERSONAL CREDIT LIMIT WHEN APPROVED. FOR YOUR CONVENIENCE WE ACCEPT MOST MAJOR CREDIT & DEBIT CARDS, CHECKS, AND CASH.

PATIENT CONSENT & SIGNATURE

BY MY SIGNATURE BELOW I ACKNOWLEDGE THAT I HAVE READ OR HAVE HAD READ TO ME AND HAVE RECEIVED A COPY UPON MY REQUEST OF THIS DOCUMENT INCLUDING THE HEALTH CARE PRIVACY NOTICE, PAYMENT TERMS & CONDITIONS, CREDIT POLICIES AND INFORMED CONSENT AND FULLY UNDERSTAND AND HAVE HAD ALL OF MY QUESTIONS ANSWERED TO MY SATISFACTION. A PHOTOCOPY OF THIS DOCUMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS AN ORIGINAL.

PATIENT SIGNATURE (OR PARENT IF PATIENT IS A MINOR)	DATE
PATIENT NAME (PLEASE PRINT)	RELATIONSHIP TO PATIENT