ORACLE PAIN CLINIC

HEALTH PRIVACY NOTICE-INFORMED CONSENT-ASSIGNMENT OF BENEFITS-AUTHORIZATION & LIEN

This office is committed to providing patients with quality health services delivered with dignity and concern. Fulfilling this commitment requires the efforts of the doctors, therapists, staff and patients working together as a team to obtain the maximum results. Patient satisfaction is important to Oracle Pain Clinic.

This practice is required by law to abide by the terms of this Health Care Privacy Notice as well as other applicable federal and state laws governing privacy practices in health care. Our facility may charge and/or modify the terms of this Notice at any time without additional notice to you except to publicly post in our Facility and/or make available to patients any updated notices. Photocopy of this Notice is available to you upon request. The term Facility refers to this office or clinic. The term Provider refers to doctors and/or licensed professionals of this facility.

Our practice & staff are committed to maintaining the privacy of your protected health information (PHI). PHI is information about you, including demographic information that may identify you and that may be related to your present, future and past physical or mental health or condition and the care and treatment you receive from our practice. This Notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please read this Notice and direct questions, misunderstandings or concerns to the Compliance Officer of this Facility.

Our Facility may use and disclose your PHI for health care delivery purposes. Your PHI may be used and/or disclosed without your written authorization by the doctors and staff of this Facility for the purposes of your care and treatment: paying your health care bills and supporting the operations of this practice. Your doctor and the staff will take all reasonable measures to maintain the confidentiality of your PHI.

The Privacy Rule allows you the right to review and receive copies of your health care records as it relates to your health care. The request must be in writing, allowing the Facility 30 days to respond. We may deny you request if it will cause harm to you or to another person. We may charge a copy fee, which will be in compliance with State law. We will comply with any reasonable request to have confidential communication by alternative means or at an alternative location if not doing so endangers you.

You may request an amendment placed in your record. If you disagree with anything in your record this does not mean that anything will be removed or changed, and we have the right to respond with a rebuttal statement if the Facility feels it is necessary. You may revoke authorization, in writing, at any time, except in the event that the Facility has acted as indicated in the doctor’s Authorization Notice.

You have the right to file a written complaint with our Compliance Officer if you believe that any of your privacy rights have been violated. You can obtain a complaint form from the Compliance Officer and/or the Officer of Civil Rights. All complaints must be filed within 180 days of when you knew or should have known that the violation occurred. The Privacy Law prohibits our Facility from taking any retaliatory actions against anyone who files a complaint. A more detailed, updated & comprehensive Health CARE Privacy Notice is available for your review in this Facility.

I understand that this practice, its doctors & staff, are accepting my case based on examination findings and believe the outlined treatment should produce change and/or improvement. However, as with any diagnostic test, procedure, examination or doctors care a guarantee of improvement or complete recovery cannot be made and it is even possible that no charge will occur.

I further understand that in the practice of medicine, chiropractic, psychological counseling, massage therapy and physical therapy there are some risks including but not limited to fractures, disk injuries, strokes, dislocations, sprains-strains, drug interactions and reactions, and/or other injuries or side effects which cannot be predetermined

I do not expect the doctor/provider to be able to anticipate or explain all risk and/or complications, and I wish to rely on the doctor/provider to exercise judgment during the course of the procedure(s) which the doctor/provider feels at the time is in my best interest. In addition, because psycho-social, spiritual, and cultural values affect a patient’s response to care, patients are allowed to express and follow spiritual beliefs and cultural practices that do not harm others or interfere with the planned course of treatment.

Patients have the right to refuse treatment but must be aware of the probable consequences of refusing treatment and/or failing to cooperate with the prescribed treatment should you refuse and/or fail to comply with prescribed treatment your provider will discuss specific consequences with you.

Therefore, I give my full consent to the doctor/provider to render treatment on me or the minor for whom I am legally responsible by a healthcare provider of this Facility.

I, the assignee, being the patient or legal guardian for said minor listed below, do hereby irrevocably authorize, direct, assign and give a full lien to the office named above and listed below, hereinafter referred to as the "Facility" against any and 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 authorizes any and all insurance companies, attorneys and third party payers to pay directly to the Facility all sums of money due them for any and all services rendered to me or minor by whom I am responsible for by reason of accident, illness and by any and all reason of any other bills that are due or may become due and to withhold such sums from any health and accident, workers compensation and or including all insurance or third party benefits

The assignee agrees that this Facility and staff may deliver medical records, consultations, depositions, and/or court appearances which must be paid in full in advance and authorize this Facility to release any information pertinent to said health care to any insurance company adjuster, attorney or legal service bureau to facilitate collection under the terms of this document. Assignee grants the Facility the full power of attorney to endorse and/or sign my name on any & all checks for payment of any indebtedness owed this office and assignee.

INSURANCE BENEFITS-CREDIT POLICIES- PAYMENT TERMS & CONDITIONS

As a courtesy, the Facility will obtain a verification of applicable insurance benefits as they are quoted to us, but some third-party payers misquote benefits, coverage and liability. Our Facility & staff are not responsible for what a third-party payer and/or representative may tell us. Any contractual, written, verbal or other obligations or arrangements between you and an attorney, insurance company, liable or third-party payer are between you and said person.

1. 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 filing or medical report charges, which you are responsible to pay.
2. Co-pays, deductions and all non-covered service charges are due on the day the service is rendered.
3. Patients are responsible for charges on all service(s) and/or product(s) which may exceed the maximum allowable and/or when a third party and/or insurance carrier does not reimburse, including automobile and work injury claims 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 settlement(s). If a third-party payer fails to pay said balance in full within the 90-day period, the patient must pay the balance in full. The assignee is fully responsible for all the money owed this facility for any and all treatment, products & services rendered to the patient or minor shown blow.
4. A non-discriminatory "Time of Service Discount" is offered to anyone who pays for the services the day they are rendered. The "TOS" is only offered on the day the service is rendered. This discount does not apply to orthopedic supports, orthotics, physical therapy equipment rentals or purchases, vitamins, supplements, ointments, acupuncture treatments, weight loss programs, psychological counseling services and massage therapy
5. A service charge is computed by a periodic rate of 1 ½ % per month- 18% per annum and is added to all balances owed 60+ days. Any balance past due 90 days or more may be submitted to an attorney and/or agency for legal collection for which the undersigned agrees to be 100% responsible for all monthly service charges, interest, cost related to but not limited to all collection-related expenses, attorney fees, count and filing fees. Returned checks, debit and credit charges made payable to this Facility for insufficient funds, stop payments or other reasons of non-payment will be assessed a $30.00 charge. Patients are eligible for a maximum $250.00 personal credit limit when approved. For your convenience we accept most major credit and debit cards.

PATIENT CONSENT AND SIGNATURE

Patient agrees that by entering into this treatment agreement he/she is giving up the constitutional rights to have any dispute arising from or relating to the medical care, procedures and surgeries received from the Physician Services and its medical staff

decided in a court of law before a jury, and instead is agreeing to and accepting the use of confidential, binding arbitration in accordance with the American Heath Lawyers Association Alternative Dispute Resolution Rules Of Procedure For Arbitration to resolve all matters.

With my signature below, I acknowledge that I have read or have read to me and received a photocopy upon my request for this document including the Health Care Privacy Notice. Facility terms & conditions, credit policies and informed Consent and fully understand and have had **all** my questions answered to my satisfaction. A photocopy of this document shall be considered as effective and valuable as an original.

_____ _____/_____/_____