Apex Chiropractic & Physical Therapy
705 GREENBAG ROAD
MORGANTOWN, WV 26508
304-292-2211

FINANCIAL AGREEMENT

YOUR INSURANCE COVERAGE/PLAN IS AN AGREEMENT BETWEEN YOU AND YOUR INSURANCE COMPANY AND ***THIS*** OFFICE. WE ***CANNOT BE*** CERTAIN IF YOUR INSURANCE COVERS CHIROPRACTIC, ALTHOUGH MANY POLICIES OFTEN PROVIDE SOME COVERAGE. THE AMOUNT THEY PAY VARIES FROM ONE POLICY TO ANOTHER. WHEN POSSIBLE WE WILL CALL TO VERIFY BENEFITS ON YOUR INSURANCE: HOWEVER, ***THE BENEFITS QUOTED TO US BY YOUR INSURANCE COMPANY ARE NOT A GUARANTEE OF PAYMENT. WE VERIFY YOUR INSURANCE AS A COURTESY TO YOU.*** YOU, AS THE PATIENT, MAY CALL YOUR INSURANCE COMPANY AS WELL. IT IS TO BE UNDERSTOOD AND AGREED THAT ANY SERVICES RENDERED MAY BE CHARGED TO YOU DIRECTLY AND YOU ARE PERSONALLY RESPONSIBLE FOR PAYMENTS OF ANY NON-COVERED SERVICES, DEDUCTIBLES, CO-INSURANCE AND/OR CO-PAYS.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENT.

SIGNATURE **DATE**

WITNESS **DATE**

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NOTICE OF PRIVACY PRACTICE

I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES AND I HAVE BEEN PROVIDED AN OPPORTUNITY TO REVIEW IT.

NAME_____

BIRTHDATE_____

SIGNATURE_____

DATE_____

INFORMED CONSENT FOR TREATMENT

PATIENT NAME: **PATIENT FILE #:**

Physicians and other health care providers are required to obtain your informed consent before starting treatment.

I _____ do hereby give my consent to the performance of chiropractic treatment that may consist of manipulations/adjustments, physical medicine and exercises. I understand that the manipulations/adjustments will involve movement of the joints and soft tissues that is considered to be one of the safest and most effective form of therapy for musculoskeletal problems.

I am aware that there are possible risks/complications associated with my treatment. Tests have been performed to minimize these risks. I freely assume the risks of treatment after having been informed of the possible risks/complications associated with my treatment as follows:

***Soreness**: It is common to experience muscle soreness during treatment.*
***Uncomfortableness**: Temporary symptoms (dizziness, nausea) can occur, but are rare .*
***Fractures/Joint Injury**: Underlying physical defects, deformities or pathologies (osteoporosis) may cause susceptibility to injury.*
***Stroke**: Strokes from chiropractic adjustments are rare.*
***Burns**: Some therapies used generate heat and may, in rare cases, cause burns.*

Treatment results: I understand there are benefits associated w/treatment including decreased pain, improved mobility and function, and reduced muscle spasms. However, I also understand there is no guarantee that I will achieve these benefits during my care, as the practice of medicine, including chiropractic, is not an exact science.

Alternative Treatments Available: Reasonable alternatives to treatment have been explained to me including rest, home therapy, exercises, medication and possible surgery.

I agree to treatment by my doctor and such persons of the doctor's choosing and provide my informed consent for treatment.

I HAVE READ OR HAVE HAD READ TO ME THE ABOVE EXPLANATION OF CHIROPRACTIC TREATMENT. ANY QUESTIONS REGARDING TREATMENT HAVE BEEN ANSWERED TO MY SATISFACTION.

_____
Patient's Signature

_____
Witness Signature

_____
Date

PATIENT STATUS AT TIME OF CONSENT:

( ) OF LEGAL AGE
( ) ORIENTED x3
( ) COHERENT/LUCID
( ) PROFICIENT ENGLISH
( ) ASSISTED BY INTERPRETER

_____

( ) MEDICATED, BUT UNIMPAIRED
( ) DENIES USE OFALCOHOL OR RECREATIONAL DRUGS PRIOR TO CONSENT
( ) UNABLE TO GIVE LEGAL CONSENT
( ) CONSENT VIA LEGAL GUARDIAN

_____

Patient's questions (if any) and responses are as follows:

Comments:

I certify that this form accurately reflects the patient's status during the informed consent process.

_____
Doctor Signature

_____
Date

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PREGANANCY WARNING AND CONSENT TO X-RAY

PATIENT NAME_____**DATE**_____

_____**I AM A MALE PATIENT. THIS DOES NOT APPLY TO ME, BUT I DO CONSENT FOR X-RAYS.**

I UNDERSTAND THAT IF I AM PREGNANT AND HAVE X-RAYS TAKEN WHICH EXPOSE MY LOWER TORSE TO RADIATION, IT IS POSSIBLE TO INJURE THE FETUS.

I HAVE BEEN ADVISED THAT THE 10 DAYS FOLLOWING ONSET OF A MENSTRUAL PERIOD ARE GENERALLY CONSIDERED TO BE SAFE FOR X-RAY EXAMS.

WITH THOSE FACTORS IN MIND, I AM ADVISING MY DOCTOR THAT:

	YES	NO	I DON'T KNOW
I AM PREGNANT			
I COULD BE PREGNANT			
I AM LATE WITH MY MENSTRUAL PERIOD			
I AM TAKING ORAL CONTRACEPTIVES			
I HAVE AN IUD			
I HAVE HAD A TUBAL LIGATION			
I HAVE HAD A HYSTERECTOMY			
I HAVE IRREGULAR MENSTRUAL PERIODS			

MY LAST MENSTRUAL PERIOD BEGAN ON_____

WITH FULL UNDERSTANDING OF THE ABOVE, AND BELIEVING THAT I AM NOT CURRENTLY AT RISK, I WISH TO HAVE AN X-RAY EXAMINATION PERFORMED.

PATIENT SIGNATURE_____

WITNESS_____

APEX CHIROPRACTIC & PHYSICAL THERAPY
AUTHORIZATION FORM
www.apexmorgantown.com

PATIENT NAME_____ PATIENT NO._____

PREGNANCY RELEASE FOR X-RAYS (FEMALES ONLY)

I hereby advise this office and doctor(s) that I am not pregnant as of this date. I release the doctors and staff from any liability for injury or complication to myself or my fetus should I be pregnant on this date. I further agree to notify this office in writing during the course of my care should I become pregnant.

Signature _____

RESPONSIBILITY OF BILL

The undersigned hereby accepts full financial responsibility for charges and services rendered to the patient. The undersigned understands that services are rendered and charged to the patient and not to the insurance company. The Chiropractic Care Center cannot accept total responsibility for collecting an insurance claim or negotiating a disputed settlement. The undersigned also agrees that this obligation shall exist regardless of private contractual agreement between the patient and any insurance carrier, attorney, or third party not signing this agreement. Financial responsibility will also include charges and services not covered by insurance for which payment is denied through utilization review or precertification procedures.

Signature _____

CONSENT FOR TREATMENT OF MINOR CHILD

Consent is hereby given by the undersigned for chiropractic treatment and diagnostic studies as ordered by the doctors and performed by the technical staff of The Chiropractic Care Center. The undersigned states that he/she is the patient's legal guardian.

Signature _____

AUTHORIZATION FOR PAYMENT OF INSURANCE BENEFITS TO PROVIDER

I hereby irrevocably authorize payment of the medical benefits otherwise payable to me to be made payable and mailed directly to The Chiropractic Care Center for professional services rendered. NO OTHER THIRD PARTY, including my attorney, should receive payment of my bills except this office for the remainder of this claim. It will be assumed and relied upon that the insurance carrier has agreed to and acknowledges medical coverage and will send payments directly to this office. This payment will not exceed my indebtedness to the doctor/ clinic. I agree that a photo static copy of this agreement shall serve as the original.

Signature _____

AUTHORIZATION TO BILL FOR SERVICES

I hereby understand that The Chiropractic Care Center offers a complimentary consultation and preliminary spinal screening/postural analysis for which there is no charge. I understand that any services beyond these complimentary services shall be billed at the usual and customary fees. Such services include, but are not limited to, examinations, x-rays, adjustments, and any therapeutic modalities.

Signature _____

_____	_____	_____	_____
PATIENT, AGENT, OR REPRESENTATIVE	RELATIONSHIP	WITNESS	DATE

MISSED APPOINTMENT POLICY

EFFECTIVE MARCH 1, 2011

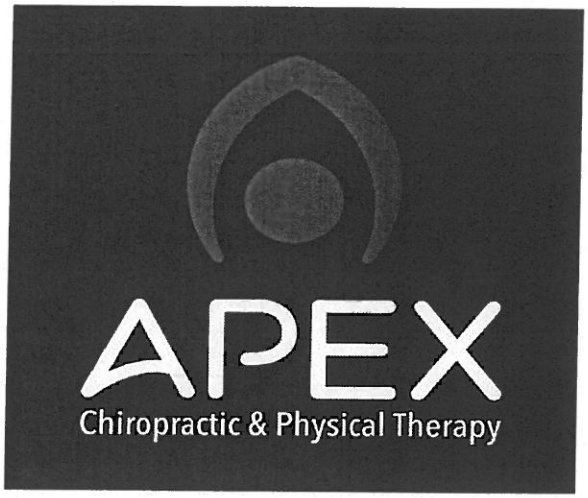
We want to thank you for choosing us as your chiropractic health provider. In order to provide you and our other patients with the best optimal spinal care, we request that you follow our guidelines regarding broken and/or cancelled appointments. Please remember that we have reserved appointments especially for you. Therefore, we request at least 24 hours notice in order to reschedule your appointment. This will enable us to offer your cancelled time to other patients that desire to get their treatment completed. When you cancel your appointment at the last minute, everyone loses – you, the doctor, and other patients that would like to have utilized your appointment time.

Our office will allow one (1) missed appointment without being charged. Including the second (2^{nd}) missed appointment, there will be a $20.00 charge added to your patient account for each missed appointment.

Thank you for your consideration of our policy and for the opportunity to be your chiropractic office of choice.

_____ _____

Patient Signature Date



Dr. Jared Surbaugh
705 Greenbag Rd. Morgantown, WV 26508
Phone: (304) 292-2211 Fax: (304)292-2282

I_____ give the Chiropractic Care Center
(Print name)

Authorization to send me appointment reminders via: PLEASE PROVIDE BOTH PHONE NUMBER AND EMAIL ADDRESS

1) Text: _____-_____-_____

2) Email_____@_____.COM

_____ _____
Signature Date

_____ _____
Witness Date

NOTICE OF HEALTH INFORMATION 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 Chiropractic Care Center PLLC is required to maintain the privacy of your health information and to provide you with a notice of its legal duties and privacy practices. The Chiropractic Care Center PLLC will not use or disclose your health information except as described in this Notice. This Notice applies to all of the medical records generated The Chiropractic Care Center, PLLC as well as records we receive from other providers.

USES AND DISCLOSURES REQUIRING YOUR CONSENT: With your consent, The Chiropractic Care Center PLLC may use and disclose your health information for the following purposes.

TREATMENT: The Chiropractic Care Center PLLC may use your health information in the provision and coordination of your healthcare. We may disclose all or any portion of your medical record information to your attending physician, consulting physician(s), nurses, technicians, medical students, and other health care providers who have a legitimate need for such information in your care and treatment. Different departments may share health information about you in order to coordinate specific services, such as prescriptions, lab work and x-rays. The Chiropractic Care Center PLLC also may disclose your health information to people outside the practice who may be involved in your medical care after you leave the office, such as family members, clergy and others used to provide services that are part of your care. Other ways we may use or disclose your health information for purposes related to treatment are:

- **Treatment Alternatives:** To tell you about or recommend possible treatment options or alternatives that may be of interest to you.
- **Appointment Reminders:** To contact you as a reminder that you have an appointment for treatment or medical care at the office.

Additionally, the Chiropractic Care Center PLLC performs treatment in a semi-private setting. If for any reason you would prefer to receive treatment in a more private area in our facility, please contact the front desk or physician to make such a request. Without your individual request, treatment will follow our standard practice in this semi-private setting.

PAYMENT: The Chiropractic Care Center PLLC may release health information about you for the purposes of determining coverage, billing, claims management, medical data processing, and reimbursement. The information may be released to an insurance company, third party payer or other entity (or their authorized representatives) involved in the payment of your medical bill and may include copies or excerpts of your medical record, which are necessary for payment of your account. For example, a bill sent to a third party payer may include information that identifies you, your diagnosis, and the procedures and supplies used. We may also provide payment information to other care providers who have been involved in your care, e.g., an ambulance company.

ROUTINE HEALTHCARE OPERATIONS: The Chiropractic Care Center PLLC may use and disclose your health information during routine healthcare operations, including quality assurance, utilization review, medical review, internal auditing, accreditation, certification, licensing or credentialing activities of the practice, medical research and educational purposes. The Chiropractic Care Center PLLC may engage outside companies to carry out certain aspects of routine healthcare operations. The Chiropractic Care Center may also release any information deemed appropriate concerning your physical condition and treatment to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by you as a result of professional services rendered and hereby release him/her of any consequences thereof. Additionally, the doctor may release any relevant findings concerning your examination and/or treatments back to your primary care physician or the office from which you were referred. These entities are called the "business associates" of the practice. The Chiropractic Care Center PLLC may need to disclose your health information to the business associates to allow them to perform their duties. The business associates will, in turn, use and disclose your health information as they conduct business on the facility's behalf. Examples of business associates, include, but are not limited to, a copy service used by the practice to copy medical records, consultants, accountants, lawyers, medical transcriptionists and third-party billing companies The Chiropractic Care Center PLLC requires the business associate to protect the confidentiality of your health information.

USES AND DISCLOSURES REQUIRING YOUR AUTHORIZATION: The Chiropractic Care Center PLLC may not disclose your health information to persons outside of the practice for purposes other than treatment, payment or healthcare operations without your authorization, unless otherwise indicated in this notice. In addition, The Chiropractic Care Center PLLC may not use or disclose psychotherapy notes written by your mental health provider, if any, without your authorization, even for treatment, payment or healthcare operations. You have the right to revoke any authorization you have previously given by submitting a written statement of revocation to The Chiropractic Care Center PLLC.

USES AND DISCLOSURES TO WHICH YOU MAY OBJECT:

FAMILY/FRIENDS: The Chiropractic Care Center PLLC may disclose your health information to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. [We may also tell your family or friends of your condition and that you are in the Hospital.] In addition, we may disclose health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location. The Chiropractic Care Center also may leave pertinent information at your home address with either a 3rd party ofr the answering machine if necessary. Information such as the time and date of your next appointment, inquiries as to how your condition is responding and requests to return the call to The Chiropractic Care Center are included in this statement. The Chiropractic Care Center and its employees may release your name as a participating patient at this office in our newsletter, email list and or referral board. The Chiropractic Care Center is also authorized via your signature on the "Acknowledgement Form" to utilize your name to call and thank the person that referred you to our office, if applicable. The Chiropractic Care Center may also utilize photographs taken our offices of you as a patient in promotional activities, including our newsletter, mailings to other patients, and in-office display boards. This privilege may be revoked by you in writing. If you have any objection to the use and disclosure of your health information in this manner, please tell us.

USES AND DISCLOSURES THAT ARE REQUIRED OR PERMITTED WITHOUT CONSENT OR AUTHORIZATION

RESEARCH: Under certain circumstances, The Chiropractic Care Center PLLC may use and disclose your health information to approved clinical research studies. While most clinical research studies require specific patient consent, there are some instances where a retrospective record review with no patient contact may be conducted by such researchers. For example, the research project may involve comparing the health and recovery of patients who received one medication for their medical condition to those who received a different medication for that same condition.

REGULATORY AGENCIES: The Chiropractic Care Center PLLC may disclose your health information to government and certain private health oversight agencies, e.g., the Department of Public Health and Environment, the Joint Commission on Accreditation of Healthcare Organizations or the Board of Medical Examiners, for activities authorized by law, including, but not limited to, licensure, certification, audits, investigations and inspections. These activities are necessary to monitor compliance with the requirements of government programs.

LAW ENFORCEMENT/LITIGATION: The Chiropractic Care Center PLLC may disclose your health information for law enforcement purposes as required by law or in response to a court order.

PUBLIC HEALTH: As required by law, The Chiropractic Care Center PLLC may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability. For example, The Chiropractic Care Center PLLC is required to report the existence of a communicable disease, such as acquired immune deficiency syndrome ("AIDS"), to the Department of Public Health and Environment to protect the health and well being of the general public.

WORKERS' COMPENSATION: The Chiropractic Care Center PLLC may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

MILITARY/VETERANS: The Chiropractic Care Center PLLC may disclose your health information as required by military command authorities, if you are a member of the armed forces.

AS OTHERWISE REQUIRED BY LAW: The Chiropractic Care Center PLLC will disclose your health information in any situation in which such disclosure is required by law (e.g., child abuse, domestic abuse).

YOUR RIGHTS RELATED TO YOUR HEALTH INFORMATION: Although all records concerning your treatment obtained at The Chiropractic Care Center PLLC are the property of The Chiropractic Care Center PLLC, you have the following rights concerning your health information:

RIGHT TO CONFIDENTIAL COMMUNICATIONS: You have the right to receive confidential communications of your health information by alternative means or at alternative locations. For example, you may request that The Chiropractic Care Center PLLC only contact you at work or by mail.

RIGHT TO INSPECT AND COPY: You generally have the right to inspect and copy your health information, except as restricted by your physician or by law.

RIGHT TO AMEND: You have the right to request an amendment or correction to your health information. If we agree that an amendment or correction is appropriate, we will ensure that the amendment or correction is attached to your medical record.

RIGHT TO AN ACCOUNTING: You have the right to obtain a statement of the disclosures that have been made of your health information other than by your authorization, other than to you and other than for the purpose of treatment, payment or routine operational purposes.

RIGHT TO REQUEST RESTRICTIONS: You have the right to request restrictions on certain uses and disclosures of your health information. If we are able to agree to your request, we will abide by the restrictions.

RIGHT TO RECEIVE COPY OF THIS NOTICE: You have the right to receive a paper copy of this Notice, upon request, if this Notice has been provided to you electronically.

RIGHT TO REVOKE CONSENT OR AUTHORIZATION: You have the right to revoke your consent or authorization to use or disclose your health information, except to the extent that action has already been taken in reliance on your consent or authorization.

FOR MORE INFORMATION REGARDING HOW TO EXERCISE THESE RIGHTS: If you have questions or would like more information regarding any of the rights listed above, please contact: The Chiropractic Care Center PLLC.

IF YOU BELIEVE THAT YOUR RIGHTS HAVE BEEN VIOLATED: You may file a complaint with The Chiropractic Care Center PLLC or with the Secretary of the Department of Health and Human Services. To file a complaint with The Chiropractic Care Center PLLC, please contact: Jaime Sipher at (304) 842-4202. All complaints must be submitted in writing. There will be no retaliation for filing a complaint.

CHANGES TO THIS NOTICE: The Chiropractic Care Center PLLC will abide by the terms of the Notice currently in effect. The Chiropractic Care Center PLLC reserves the right to change the terms of this Notice at any time. Any new notice provisions will be effective for all protected health information that it maintains. The Chiropractic Care Center PLLC will mail any revised Notice to the address indicated on the patient information forms or such other address you may provide to us from time to time. A photostatic copy of this agreement and the HIPPA acknowledgement form shall serve as the original.

NOTICE EFFECTIVE DATE: The effective date of the Notice is April 1, 2003.