Notice of Privacy Practices

Tulsa Chiropractic Rehab, DBA Reactivate Chiropractic & Rehab
8252 S. Harvard Ave. suite 155
Tulsa, OK, 74137-1646

Protecting our patient's Private Health Information (PHI) is one of our clinic's top priorities. PHI is information that relates to a patient's physical health or mental health or condition, the provision of health care to the patient, or payment for the provision of health care to a patient. Our full Notice of privacy practices policy is available upon request. We consider PHI confidential and have policies and procedures in place to protect it against unlawful use and disclosure. We do not sell our patients information to third parties. PHI does not include publicly available information or information that is available or reported in a summarized or aggregate fashion but does not identify the patient.

When necessary or appropriate for your care or treatment, the operation of our care plans, or other related activities, we use PHI internally, share it with our affiliates, and disclose it to health care providers, healthcare provider organizations, employers who sponsor self-funded health plans or who share responsibility for the payment of benefits, others who may be financially responsible for payment for the services or benefits the patient receives under the plan, other insurers, third party administrators, vendors, consultants, government authorities, and their respective agents. These parties are required to keep PHI confidential as provided by applicable laws.

As participating network providers, we are required to give patients access to their medical records within a reasonable amount of time after the patient makes a request. Our office has the right to charge for medical records as provided by law. You have the right to ensure the accuracy of your health record, request limits on the use and disclosure of information, and request an accounting of the use of your PHI. You have the right to notice of privacy of personal health information, the right to access and inspect your medical records, the right to amend your medical records, the right to authorize or deny uses of treatment for other purposes such as research, the right to audit disclosures, the right to request restriction on use of your information, the right to request alternative channels of communication, and the right to make a complaint to your provider and/or with the secretary of the U.S. department of health and human services regarding use of your PHI (see the office for civil rights website at www.hhs.gov/oct/hipaa for more information).

Some of the ways in which patient health information is used include: for the purposes of treatment; for the purposes of payment; to HMOs and third party administrators; for transfer of policies or contracts to and from other insurers; for underwriting activities; for health services research; for utilization review and management; for medical necessity reviews; for coordination of care and benefits; for preventative health, for early detection and disease and case management; for health care operations; for auditing and anti-fraud activities; for performance measurement and outcomes assessment; for data and information systems management; for quality assessment and improvement activities; for medical residents or medical students associated with the clinic; with business associates as permitted by law (i.e. tech support); for appointment reminders; to provide you with treatment options; to family/friends when they are involved with your care; to inform you about health-related benefits or services; for health related communications such as emails or newsletters; for disaster relief; for promotions & marketing within the limits of the law; for fundraising as permitted by law; for public health activities; to funeral directors; for adverse events reported to the Food & Drug Administration; to mental health professionals when appropriate; to coroners; for the purpose of research; for workers compensation; in compliance with law enforcement officials; in compliance with legal and regulatory requirements; for the purposes of de-identified information; to appropriate personal or legal representatives; for litigation proceedings; and for special testing as required by law. We consider these activities key for the operation of our practice. To the extent permitted by law, we use and disclose PHI as provided above without patient consent. We also have policies addressing circumstances in which patients are unable to give consent.

Signing below indicates you have read or have been read/translated and understand the above privacy disclosure:

_____	_____	_____	_____
Patient Name	**Patient/Guardian Signature**	**Relationship to Patient**	**Date**

_____	_____	_____
Witness Name	**Witness Signature**	**Date**

Tulsa Chiropractic Rehab, DBA Reactivate Chiropractic & Rehab
8252 S. Harvard Ave. Suite 155, Tulsa, OK 74137
Dr. David Fields (918) 600-2969

Informed Consent for Examination and Treatment

I (we) hereby consent to the examination and treatment of _____, by the licensed Doctor(s) of Chiropractic, Medical Doctor(s), Licensed Therapist(s), and/or Assistant(s) who may be employed by or engaged in practice at this clinic.

I understand that neither chiropractic, physiotherapy, massage, nor medical treatment is an exact science and that my care may involve judgements based upon facts and information known to the doctor/therapist(s). The doctor/therapist(s) use their judgement to attempt to anticipate or explain risks and complications and undesired results do not necessarily indicate an error in judgement. IV and injection therapy may be considered unproven and medically unnecessary for its use but is sometimes recommended for its potential benefits and its use is intended to improve a condition and/or achieve a particular health effect. It is possible that care may not mitigate, alleviate, or cure the condition for which it has been prescribed. No guarantee for results can be made or expected, but rather I wish to rely on the doctor/therapist to choose and recommend a best course of treatment based upon facts known that is in my best interest.

I understand that there are certain degrees of risk associated with the treatments chiropractic, massage, and physiotherapy which includes rarely, but not limited to fractures, disc injuries, burns, strokes, and strains/sprains, rash, abrasions, and bruising. Injectable and IV therapies can carry certain degree of risk including: pain and bruising at the site, the risk of infiltration (needle outside vein), vascular injury, diarrhea, muscle spasms, weakness, fatigue; and rarely loss of consciousness, development of blood clots, thrombophlebitis, infection, and allergic reactions.

I am willing to accept and consent to the risk associated with the care that I am about to receive. I understand that I may suspend or terminate my treatment at any time by informing my doctor/therapist(s). I further understand and agree to adhere to the recommendations given by the doctor/therapist(s) including the recommended treatment schedule and any follow up to permit observation and study my progress. I assume full liability for any adverse effects that may result from the non-negligent administration of the proposed treatment. I waive any claim in law or equity for redress of any grievance that I may have concerning or resulting from the procedures, except as that claim pertains to negligent administration of said procedures.

I hereby place myself under the care of the doctor/therapist(s) at this clinic and verify that all information presented by me to this clinic in my history is true to the best of my knowledge. I am not misrepresenting myself and I place myself under care at this clinic for the sole purpose of treatment for the conditions indicated by me. I understand it is my responsibility to inform the doctor/therapist(s) at this clinic of any change in my condition or new condition that would affect my care, and omission of such information could be detrimental to my health.

I have read, or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition, and for any further conditions for which I seek treatment.

_____	_____	_____
Patient's Name	Patient/Guardian Signature	Relationship to Patient
_____	_____	_____
Witness Name	Witness Signature	Date

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FINANCIAL POLICY

At this clinic, we offer several options for payment with affordable plans to fit your needs. Our fees are considered usual, customary, and reasonable by most companies; and therefore, are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area.

Returned checks will incur a fee of $30 or the bank's fee for the bounced check, whichever is greater. Every 30 days of overdue balance, a late fee of up to $10 may be applied, plus interest charges of up to 15% annually. Decline fees of up to $10 may be applied for any decline on a credit/debit/HSA card charge, and balances will be subject to all late fees and interest. Appointment cancellation notice of 24 hours is required to avoid any fee. Chiropractic cancellation fees will not exceed $50 per visit. Massage cancellation fees are $40 per hour scheduled. Cancellation fees for other services will not exceed the price of the visit. Fees for materials procured for your planned services are not refundable. You understand that repeated cancelled or missed appointments are grounds for termination of care rendering any unpaid balance due immediately. You further understand that overdue accounts may be forwarded to an outside agency after 90 days and you will be responsible for any fees generated resulting from collection efforts. From time to time, circumstances outside the clinic's control may result in cancelling appointments on our schedule (Illness, weather, emergency, etc.). In such cases, we will give as much advanced notice as possible and will extend you the same courtesy.

You agree to conduct yourself as a patient in an appropriate manner. Disruptions, harassment, or outright violence will not be tolerated. The safety and security of the patients and staff at the clinic come before any one individual's needs. Should such a circumstance occur, you may be warned once before being asked to leave the premises. Should this occur during a service, the service will be terminated and there will be no refund for said services.

If you discontinue care for any reason other than discharge by the doctor(s) and/or therapist(s), all balances will become immediately due and payable in full by you, regardless of any claim submitted, and this clinic retains the right to use any credit/debit/HSA card on file to obtain such payment at the time of discontinuance and/or shortly thereafter in more than one distinct charge if necessary in order to zero your balance(s). Non-covered products/services cannot be refunded and promotional value is forfeit if not utilized within a timely manner.

You as the patient will decide which of the three options below you will use. It is also your responsibility to provide us with the necessary payer information, and failure to do so may result in unforeseen expenses.

1. If You Do Not Have Insurance or Elect Not to Use Your Insurance: All payments are expected at the time of service or by an authorized payment plan. Massage services are to be paid before receiving the service. Your personal balance may not exceed $100 at any time or care may be terminated. We accept cash, checks, and credit cards. We offer legal discounts to members of certain discount programs for reimbursable services that are not covered by your insurance or for which you elect not to use insurance. Services provided by massage therapist(s), acupuncturist(s), or any other service provider not in network with your insurance at our clinic and not part of an active chiropractic care plan are considered not billable to insurance and have a distinct fee schedule for which discount membership fee reductions may not apply, but promotional discounts may be available. Similarly, products and services that are considered not reimbursable will not be discounted under any discount membership program but may be reduced by promotion or other fee change.

2. If You Have Insurance and Elect to use it: Our policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out-of-pocket expenses. You hereby assign all applicable health insurance benefits to which you and/or your dependents are entitled to us. You hereby authorize us to submit claims on your and/or your dependents' behalf, to the benefit plan (or its administrator) listed on the current insurance card you provided to us, in good faith. You also hereby instruct your benefit plan (or its administrator) to pay provider directly for services rendered to you or your dependents. You are responsible for payment in full until we qualify and accept your insurance coverage. We will make our best effort to verify your insurance benefits and inform you of our findings. We may attempt to estimate the cost of your visit(s), but the estimate is not a guarantee as we do not have control over your coverage. You agree to pay any relevant copay or deductible at the time of service. Coinsurance will either be billed, or you will be responsible for your portion at the time of service. You agree to be responsible for immediately notifying our office of any change in insured status and any failure to do so that causes our inability to collect from your health insurance provider will result in you being responsible for any unpaid balance at our standard fee schedule rates or discount membership fee schedule, whichever applies. Any misinformation provided by you that results in the inability to collect from your health insurance provider will also result in you being responsible for any unpaid balance at the applicable fee schedule. Some services may not be reimbursed by insurance, and these services will be your responsibility to pay. Your insurance coverage, including Medicare, may not pay for non-covered services including: exams, injections, IV therapies, supplements, therapeutic devices, equipment, massage, physical therapies, and services/procedures considered experimental or not medically necessary by the insurance company. You will be responsible for payment on any and all of these non-covered or non-reimbursable services. If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance and authorize us to use your credit/debit/HSA card on file to collect full payment. When your schedule of visits is of a frequency of once a month or less, or you reach maximum improvement, or the intention of care is preventative or to maintain your progress, your insurance will not cover the care as the insurer considers this wellness/maintenance care. Federal law clearly prohibits billing Medicare and other insurers for maintenance/wellness care as active care and considers this fraud: we do not code this way.

3. If You Have a Personal Injury Case: You are ultimately financially responsible for treatment provided, though the clinic may offer to postpone payment until you settle your case. For cases in which payment is being postponed until settlement, our full fee schedule will be applied to products and services rendered as discount memberships only apply when payment for care is due at the time of rendering. We retain the right to file a lien against any relevant settlement to pay your balance. Settlement of your case also results in payment of your balance being due immediately. It is our policy to use any available med-pay or non-insured motorist insurance under your policy or other relevant policy. You agree to obtain and share with us such benefits information and file the relevant claim by your second visit. If you have no coverage under your own auto insurance policy, you agree to retain a lawyer and share the lawyer's information with us within one week of starting care. If your settlement does not cover the expense of care, in part or in full, you may be held responsible for payment of the remaining balance on your account at our standard fee schedule. You agree to pay your balance in full or by arranged payment plan at settlement or at the time it is discovered there is no coverage under a third party payer.

Signing below indicates that you have read, understand, and agree to the above terms and conditions.

Patient's Printed Name: _____

Signature: _____ Date: _____

Verified by Staff Member: _____ Date: _____