INFORMED CONSENT TO TREATMENT

I hereby request and consent to the performance of chiropractic manipulation and any other chiropractic procedures, including examination, physiotherapy techniques, and diagnostic tests ordered by the Doctor of Chiropractic who now or in the future renders treatment to me while employed by, associated with or serving as temporary coverage for Amanda J. Meyers DC, MS, PC t/a Body Logic, PC ("Body Logic"). The nature of chiropractic treatment and possible complications: The primary chiropractic treatment used by Body Logic is spinal manipulative therapy and this procedure may be used during your treatment. As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and physiotherapy. These complications, while very rare, may include, but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains, stroke and burns. Some patients may feel some stiffness or soreness during the first few treatment sessions, a feeling that is often compared to starting a new exercise program. Every reasonable effort will be made to screen for contraindications to care; however, if you have a condition that would not otherwise be apparent to the Doctor of Chiropractic's attention, it is your responsibility to inform him or her. I have read or have had read to me the above explanation of treatment. By signing below, I state that I have weighed the risks verses benefits of chiropractic treatment and have decided that it is in my best interest to undergo the treatment recommended by the Doctor of Chiropractic affiliated with Body Logic.

I hereby give my consent to that treatment, and I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment through Body Logic.

Printed Name: __________________ Signature: _____________________Date:___________

WITNESS:

Printed:______________________ Signature:________________________ Date____________

Authorization to Request or Release Medical Information

To: ____

I authorize Body Logic, PC to release or request all or part of my medical records to and/or from other health-care providers (i.e. chiropractors, physicians, clinics, hospitals, etc.) involved in the care of my condition. Body Logic, PC is further authorized to release such information as may be necessary or required for statistical reporting, in relation to insurance claims, or as required by applicable law.

Patient Name: ____

Patient DOB: ______________

I understand that all disclosures under this authorization are to be made in compliance with applicable federal and state laws governing the use and disclosure of health information. I understand that I have the right to limit the type of information released and to revoke this authorization by submitting a notice in writing to Body Logic. Unless revoked, this authorization will expire one year from the date of my signature below. If I choose to limit the information release, I understand that Body Logic may inform the requestor that portions of the record have been withheld. I understand that the information disclosed may be subject to re-disclose by the recipient and such re-disclosure will not be protected by Body Logic.

I authorize the request/release of my medical records as indicated below:

- o All medical records relating to my condition including without exception clinical notes, testing, treatment, consultations, secondary records, etc.
- o Partial records which may include information above with the exception of:
  ____
  ____

An electronic or photo static copy of this authorization is to be considered as valid as the original.

Signature of Patient: ____ Date: ____________

Printed Name: ________________________________ Relationship to patient: ____________

Policy Regarding Required Information and Payment of Account

Prior to treatment, all patients requesting services are required to provide Amanda J. Meyers, DC, MS, PC t/a Body Logic, PC ("Body Logic") with the following information: 1. For patients who have been involved in a personal injury or automobile accident, complete insurance information for the responsible party regarding the accident; 2. The patient's personal health insurance information; and 3. Contact information for any attorney retained by the patient in regards to any pending or potential claim relating to a personal injury or automobile accident. Insurance, please note that your insurance policy is an agreement between you and your insurer, not between your insurer and Body Logic. Like all types of care, coverage for chiropractic services varies from insurer to insurer and plan to plan. Most insurance policies require the beneficiary to pay co-insurance, co-payment and/or a deductible. (For example: if you have a deductible of $100, and your insurance pays 80%, you are responsible for 20% of all charges incurred during the year after you have paid your $100 at the beginning of the year.) Body Logic will call your insurer to verify your available benefits, however, we are not responsible for your insurer's final determinations as to payment and benefits.

Payment Options: There are three payment options available to patients in order to receive treatment at Body Logic. In order to help you determine your responsibility toward payment for services, please read the following, and initial your preference for the method of payment for your account:

1. _____As I have no insurance, I agree to assume all financial responsibility for my treatment and to keep my account current by paying for services when they are rendered.

2. _____ I have insurance that is out of network with Body Logic, and I agree to assume all financial responsibility for my treatment and to keep my account current by paying for services when they are rendered.

3. _____I have insurance, but I wish to file my claims personally, and I agree to assume all financial responsibility for my treatment and to keep my account current by paying for each visit at the time services are rendered.

4. _____I would like Body Logic to bill my insurance. I understand that I am responsible for all costs of treatment, and I agree to assume such financial responsibility.

Although you are ultimately responsible for payment of your account, for patients who have been involved in a personal injury or automobile accident, Body Logic will accept assignment of benefits from the Medical Pay portion of your auto insurance or the responsible parties' insurance upon execution of an assignment of benefits. If the claim is settled or if you suspend or terminate care, all fees for services that remain unpaid will be immediately due and payable. Please notify Body Logic if the status of your insurance changes.

Missed Visit Policy It is the policy of Body Logic to assess a $40.00 missed visit fee to patients who cancel appointments with less than a 24-hour notice. One missed visit will not result in the assessment of a fee, but you will be charged for any additional missed visits. Body Logic provides care for many individuals and missed visits result in time lost that could have been used to provide care for others. My initials here indicate that I understand the above missed visit policy: ______

Patient Acknowledgment: I agree to the terms and conditions listed above. Should there be any changes with my financial arrangements, I will notify Body Logic immediately so that other arrangements can be made.

Patient Signature: ___________________________________ Date: _____________________

Witness: ____ Date: ______________________

Permission to Access Patient Records/ Emergency Contact

I, ________________________________, hereby give permission to the following person or persons to be able to have access to my records and medical information that is performed or recorded at Body Logic.

Name:____

Relation to you: ________________________________

Name:____

Relation to you: ________________________________

Name:____

Relation to you: ________________________________

If you do not wish to grant any one access to your records or information that is pertained at Body Logic, please sign here stating that you are not allowing anyone access.

Print Name:____

Signature:____

In the case of an emergency, please provide for us who you would like for us to contact by stating their name and best phone number to reach them by followed by your signature. Thank you.

First name:_____________________________ Last name:_____________________________

Relation to you: ______________________________

Phone #: _____________________________

Signature:_______________________________________ Date:_________________________

HIPAA 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.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

____________________________________ ______________________________
Signature of Patient or Representative Date

____
Printed Name

HIPAA ACKNOWLEDGEMENT

According to the guidelines and regulations put in place by HIPAA, we as an office are to make sure that all patients have signed this acknowledgement stating that they have signed two HIPAA documents, one to remain in the office and one for the patient to keep for their own personal records. Please print and sign your name as well as the date that you signed the acknowledgement. Thank you for your understanding and helping Body Logic remain compliant with HIPAA regulations and guidelines.

By signing this document, you are acknowledging that you have signed and received a copy of our HIPAA policy. Thank you.

Printed name of patient: ____ Date:________________

Signature of patient: ____ Date:________________

Signature of parent or guardian if patient is a minor:

____ Date:_________________