PATIENT BILLING FORM

Please always attach: COPY DRIVING LICENSE and INSURANCE CARD front and back to this form.

For provider only:
Assigned provider Mikolaj Gozdalski, D.C.
Referring provider (for Medicare only) _________________________
Initial visit ____/_____/_____
and Authorization for Assignment and release signature date Box 12, 13

Patient demographic and insurance information:

Patient First Name: _____________Last Name: ______________________Middle name: ____________

DOB: ___/_____/_____ Sex: _____ Marital Status: __________________

Address: ______________________________ City: __________________ State: ____ Zip: __________

Phone number: __________________________

Reason for Visit

Please indicate the reason for your visit and the method of coverage you will be using for your treatment(s).

Motor Vehicle Accident _______ Workers Compensation ________ Health Insurance ________

PRIMARY INSURANCE:

Insurance name: _________________ Insurance ID: ___________________group number: ___________

POLICYHOLDER information:

Policyholder name: ________________________ DOB: _______________Sex: __________

Relationship to insured: _____________________

SECONDARY INSURANCE:
Insurance name: _______________________
Insurance ID: ___________________ group: ______________

Therapy Plus Health Solutions Inc.

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

__________________, hereby states that by signing this Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out is health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3. I understand that, and consent to, the following appointment reminders that will be used by the Practice: a) a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone.

4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.

5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.

7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.

8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

______________________________ Name of Individual (Printed)	______________________________ Signature of Individual
______________________________ Signature of Legal Representative	______________________________ Relationship (e.g., Attorney-In-Fact, Guardian, Parent if a minor):
Date Signed ____/____/____	Witness: __________________________

CONSENT TO CHIROPRACTIC EXAMINATION AND CARE

I hereby authorize ("the Practice known as Therapy Plus Health Solutions") and its licensed doctors, practitioners and assistants, based on my complaints and the history I have provided, to undertake an examination and provide an evaluation and treatment plan which may include chiropractic adjustments and other tests and procedures considered therapeutically appropriate. I understand that Illinois law entitles me to receive information concerning my condition and proposed treatment, and to refuse any treatment to the extent permitted by law. With that knowledge and with my consent, I wish to rely on the Practice doctors to make those decisions about my care, based on the facts then known, that they believe are in my best interest.

The nature and purpose of the chiropractic examination and evaluation, the chiropractic adjustments and the other procedures that may be recommended during the course of my care have been explained and described to my satisfaction.
Based on current findings, Practice doctors have discussed my diagnosis and treatment plan, the benefits and expected improvement with the proposed treatment and the reasonable alternatives to the proposed treatment. They have also explained the cost of my proposed care (or provided me with a current fee schedule) and to the extent practicable the costs of reasonable alternatives to the proposed treatment.

Practice doctors have also explained that my diagnosis and treatments may change during the course of care and that they will advise me of material changes in my diagnosis and treatment options and answer any additional questions that I may have at any time.

I have also been advised that although the incidence of complications associated with chiropractic services is very low, anyone undergoing adjusting or manipulative procedures should know of rare possible hazards and complications which may be encountered or result during the course of care. These include, but are not limited to, fractures, disk injuries, strokes, dislocations, sprains, and those that relate to physical aberrations unknown or reasonably undetectable by the doctor.

This document is intended as a general, broad-based consent applicable to any and all contemplated procedures. However, without in any way limiting the general applicability of this Consent, in the event the Practice has recommended that I undergo cervical (neck) adjustment or manipulation based on my diagnosis and condition, the Practice has also informed me specifically regarding cervical (neck) adjustment and manipulation as follows: There is a rare association of this type of adjustment or manipulation with stroke due to compromise of the vertebrobasilar (VBA) artery (a neck artery at the base of the brain). In 2008, the risk was reported to be 1 case per 400,000 to 1,000,000 cervical spine adjustments in a study of VBA stroke patients admitted to Ontario hospitals from 1993 – 2002. [1] To the best of my knowledge, this is the largest research study to date on this issue. The study found positive association between *both* primary care (medical) visits and chiropractic visits with VBA stroke in this patient

[1] Cassidy JD, Boyle E, Cote P, *et al.* Risk of vertebrobasilar stroke and chiropractic care: results of a population-based case-control and case-crossover study. *Spine*, Feb 15 2008;33(4 Suppl):S176-183. Republished in *J Manipulative Physio. Ther,* 2009 Feb;32(2Suppl):S201-8.

population. The study also found that practitioner visits billed for headache and neck complaints were highly associated with subsequent VBA stroke.

The study concluded that VBA stroke is a very rare event in the population, and that the increased risks of VBA stroke associated with chiropractic visits and primary care (medical) visits is likely due to patients with headache and neck pain from VBA dissection seeking care before their stroke.
The study found no evidence of excess risk of VBA stroke associated with chiropractic care compared to primary care.

Some organizations, media outlets and Internet sites have publicized statements asserting an anecdotal association between neck manipulation or adjustment and VBA stroke. However, the Practice believes that the Ontario study cited above is the largest controlled study and the best scientific evidence on the subject at this time. Additionally, the anecdotal conclusions fail to identify other activities of equal risk. A peer-reviewed medical journal has reported the "beauty parlor stroke syndrome" in which the writer suggests that certain people with arterial defects may be more susceptible to stroke by hyperextending and their necks in a shampoo bowl.[2] Another study reports that abrupt changes in head position, such as rotating of the head when backing up a car, can increase risk of stroke in vulnerable patients[3]. Finally, evidence indicates that neck manipulation produces far less risk of serious side effects than: spine surgery[4]; the combined use of nonsteroidal anti-inflammatory drugs (NSAIDS) and aspirin[5]; and the use of aspirin alone[6].

I have discussed all of the above risks and benefits with the Practice, and, if applicable, have made an informed decision that the potential benefits outweigh the risks in my case.
I understand and accept that:

1. I have the right to withdraw from or discontinue any treatment at any time and that the Practice doctors will advise me of any material risks in this regard.

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[2] *The Lancet*, Volume 350, Issue 9093, Pages 1777 - 1778, 13 December 1997

[3] *Stroke*.1981; 12: 2-6

[4] Smith, JS et al. Rates and causes of mortality associated with spine surgery based on 108,419 procedures: a review of the Scoliosis - Research Society Morbidity and Mortality Database. Spine 2012, Nov 1;37(23):1975-82.3. Marquez-Lara A, Nandyala SV, Hassanzadeh H, Noureldin M, Sankaranarayanan S, Singh K: Sentinel Events in Cervical Spine
Surgery. Spine 2014 Jan 29 [Epub ahead of print],
http://www.ncbi.nlm.nih.gov/pubmed/24480955
[5] Lanas A et al. A nationwide study of mortality associated with hospital admission due to severe gastrointestinal events and those
associated with nonsteroidal anti-inflammatory drug use. Am J Gastroenterology 2005, Aug;100(8):1685-93.
[6] Lanas A et al. A nationwide study of mortality associated with hospital admission due to severe gastrointestinal events and those
associated with nonsteroidal anti-inflammatory drug use. Am J Gastroenterology 2005, Aug;100(8):1685-93.

2. That neither the practice of chiropractic nor medicine is an exact science and that my care may involve the making of judgments based upon the facts known to the doctor during the course of my care.
3. That it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications or an undesirable result does not necessarily indicate an error in judgment or treatment.

4. The Practice does not guarantee as to results with respect any course of care or treatment.

5. My care and treatment will not be observed or recorded for any non-therapeutic purpose without my consent.

I have read this Consent (or have had it read to me) and have also had an opportunity to ask questions about the Consent and understand to my satisfaction the care and treatment I may receive. My signature below acknowledges my consent to the examination, evaluation and proposed course of care and treatments by the Practice. I have signed this form AFTER reviewing my treatment plan with the Practice.

____

Patient's Printed Name

____

Patient's Signature

____

Witness

Financial Policy

Office Financial Policy for Therapy Plus Health Solutions Inc.

Welcome to Therapy Plus Health Solutions Inc. Our goal is to provide our patients with the best possible care and to maintain a good physician-patient relationship. We believe that these objectives are best achieved when our patients are clearly informed of our financial policy. Please review this policy carefully. We encourage patients to freely communicate with our office and to review any questions with our staff.

Insurance Coverage

By receiving services from this office, you have created a legal obligation between you and this office, and you are agreeing to pay for our services. This legal obligation exists independently and regardless of insurance or health benefits you may have. Your insurance policy or health plan is an agreement between you and your insurer, not between your insurer and this clinic, even if this office is a participating provider in your insurance network, and even if we agree to bill your plan. You agree that you intend, to the full extent allowed by law, for the legal obligation between you and this office to take priority over any agreement between you and your insurer or health plan, or any agreement between your insurer or health plan and this office. In the event discrepancies exist in the agreements between and among you, this office and your health insurer or health plan, you intend for this Financial Policy to control. Therefore, you acknowledge your obligation to pay this office for any and all services rendered, regardless of whether insurance coverage is denied at any time and **for any reason**, including but not limited to the insurer's or plan's determination that a procedure is not medically necessary or is experimental and/or investigational.

Insurance coverage for the services we provide varies from insurer to insurer and plan to plan.

Our clinic will contact your insurer or health plan to inquire about your benefits. However, most insurers and health plans provide that an initial "verification" of coverage is not a guarantee of payment. We are not responsible for your insurer's or health plan's final benefit determinations, and you are responsible to pay for any care that is determined to be non-covered, even after an initial verification of coverage.

You are responsible for obtaining the details of your insurance coverage in advance of your visit. However, be aware that most insurers and health plans provide that an initial "verification" of coverage is not a guarantee of payment. We are not responsible for your insurer's or health plan's final benefit determinations, and you are responsible to pay for any care that is determined to be non-covered even after an initial verification of coverage.

Patients and/or this clinic may obtain information indicating that a contemplated service or services will not be covered by insurance or the health plan. Additionally, some plans require pre-authorization as a condition of payment for certain services, after which the plan may deny or limit authorization of the services requested. In any case in which a patient and/or this clinic know that contemplated services will not be covered by a patient's insurance, this office will ask

the patient prior to service to sign a form acknowledging that the services will not be covered and that the patient will be personally responsible for payment.

Most insurance policies and health plans 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%, first you must pay $100 out-of-pocket at the beginning of the year, and then you are responsible for 20% of all charges incurred during the remainder of the year. Our clinic requires the payment of these fees. This office does NOT routinely waive co-insurance, co-payments or deductibles. However, this office permits patients to apply for discounts or waivers of fees to be granted to qualified individuals in limited circumstances under our Financial Hardship Policy. If you are interested in more information, including the factors we consider to make hardship determinations, please request a copy of our Financial Hardship Policy and application.

If your insurance or health plan requires you to obtain a written referral from your primary care provider as a condition to your receiving services from our clinic, it is your responsibility to obtain and present the referral prior to or at the time of your visit to our clinic. If your plan requires our office to complete a referral for services outside of our office, we require 3 business days to complete the forms, except in emergencies. Please plan your visits accordingly.

Billing and Payment

This office accepts cash, checks , debit and credit cards.

As a courtesy, we will submit bills to your insurance if you are covered by a plan in which we participate. You may be required to sign an Assignment of Benefits as a condition to our billing your insurance. However, the Assignment of Benefits does not cancel your financial obligation to this office. Full payment is due at the time of service for uninsured patients; for patients who are covered by a plan in which our office participates but services are not covered; or for patients who are insured by a plan in which this office does not participate.

Full payment is due at the time of service. If we do not bill insurance, will provide you with a standard form itemized bill so that you may submit the charges to your insurance or health plan for reimbursement.

All remaining balances are due upon receipt of the billing statement. Any accounts not paid within **90** days of the statement date will begin to accrue interest at 9% per annum and will be turned over for collection.

In cases of separation, divorce and/or shared custody, any adult patient accompanying a minor child to an appointment is responsible for payment, regardless of the terms of the separation or divorce. It is the responsibility of family members, not this office, to resolve legal disputes, and terms of a divorce do not supersede the legal obligation for the accompanying parent to pay for our services. However, we understand that temporary financial issues may affect timely payment, and we encourage patients to contact our staff regarding payment arrangements in such situations.

Medical Records Copying and Transferring

Medical records will be released within 30 days of request pursuant to your valid written authorization, in accordance with the rules for the Health Insurance Portability and Accountability Act (HIPAA), Illinois law, or under other circumstances required by law. We will charge copying fees as permitted by law.

Medical Forms, Reports, Testimony and Miscellaneous Fees

This office will fill out routine forms at no charge. However, we reserve the right to determine which forms are routine in nature. Our physicians may provide additional services, such as expert review and consultation, narrative reports, testimony at depositions and trials, or family conferences, at an hourly rate. Should you need these services, please see our staff for further details.

I understand and agree to all terms and conditions of this Financial Policy, including the provision that all health services rendered to me and charged to me are my personal financial responsibility.

Please sign below.

____ ________________________
Signature of Patient or Responsible Party Date

____
Printed Name of Patient or Responsible Party

Patient Payment Agreement and Credit Card Authorization

Patient Payment Responsibility Agreement

Thank you for choosing Therapy Plus Health Solutions Inc. for your physical therapy and chiropractic needs. To ensure a smooth billing process and to protect both the clinic and our patients, we are implementing a payment policy requiring all patients to provide a valid credit card on file. This policy helps us manage cases where patients may have outstanding balances for services not fully covered by their insurance.

1. Credit Card on File

By signing this agreement, you authorize Therapy Plus Health Solutions Inc. to keep a copy of your credit card on file to be used only in the event of a default in payment for services rendered. This credit card copy will be securely stored and will not be used for any other purpose without your prior authorization.

2. Default Payment Authorization

If a balance remains unpaid on your account, Therapy Plus Health Solutions Inc. reserves the right to charge the credit card on file. However, this charge will only occur after:

- Three (3) invoices have been sent to you regarding the outstanding balance.
- A legitimate and honest attempt to contact you has been made, which may include phone calls, emails, or mail correspondence to notify you of the balance and request payment.

If payment or a payment arrangement is not received after these attempts, the clinic will proceed with charging the outstanding balance to the credit card on file.

3. Fees

In the event that the credit card on file is charged for an overdue balance, the following fees may apply:

- **Inconvenience Fee:** A 9% fee will be assessed to cover additional administrative efforts.
- **Credit Card Processing Fee:** A credit card processing fee of 5% will be applied to the total charged.

4. Security and Confidentiality

Therapy Plus Health Solutions Inc. takes the security of your financial information seriously. The credit card information will be securely stored and will be used solely for the purpose stated above in the event of a payment default. It will not be shared, distributed, or used for any other purpose without explicit authorization.

In the event of a data breach that may compromise your credit card information, Therapy Plus Health Solutions Inc. will contact you immediately to inform you of the breach and advise you on any necessary steps to protect your information.

5. Patient Acknowledgement

By signing this form, you acknowledge and agree to the terms and conditions listed above. You understand that Therapy Plus Health Solutions Inc. reserves the right to charge the credit card on file if your account becomes overdue and to apply any fees as detailed in this agreement. You further acknowledge that the clinic will only proceed with such charges after sending three invoices and making a legitimate attempt to contact you.

Patient's Full Name: ____

Date of Birth: ____

Patient's Signature: ____

Date: ____

Clinic Representative's Signature: ____

Date: ____