PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process, except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider, including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here. _____. Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

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ALSO **SIGN** THE **INFORMED CONSENT** ON **REVERSE** SIDE

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures, if indicated. Any examinations or tests conducted will be carefully performed, but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including, but not limited to, hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people, whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE

Clayton Chiropractic Clinic
917 E. Country Hills Drive, Suite 4 • South Ogden, Utah 84403
Phone: (801) 621-1668 • Fax: (866) 723-7266 www.claytonchiro.com

Patient Name: _____ **Identification Number** (optional)**:**_____

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for the Item(s) or Service(s) below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the Item(s) or Service(s) below.

Item(s) or Service(s)	Reason Medicare May Not Pay:	Estimated Cost
___Chiropractic Adjustment (1)	1. Medicare will pay for this Item or Service when deemed medically necessary, but no more often than the Frequency Limit.	$50 - $70
___Therapy (2)		$20 - $65
___Examination (2)		$40 - $170
___X-rays (2)		$50 - $180
___Supplements / Vitamins (2)	2. Medicare does not pay for these Item(s) or Service(s). They are not covered.	$5 - $90
___Medical Equipment (2)		$25 - $150
___Other Supplies (2)		$5 - $20

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the Item(s) or Service(s) listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

OPTIONS: **Check only one box. We cannot choose a box for you.**

☐ **OPTION 1.** I want the Item(s) or Service(s) listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the Item(s) or Service(s) listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

☐ **OPTION 3.** I don't want the Item(s) or Service(s) listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

Additional Information: You may choose to receive some, but not all of the Item(s) or Service(s) listed above. You may mark the space next to the Item(s) or Service(s) that you **do** wish to receive, or cross out the Item(s) or Service(s) that you **do not** wish to receive.

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

Signature:	**Date:**

Clayton Chiropractic Clinic

AUTHORIZATION, ASSIGNMENT & RELEASE FORM

AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred.

2. I authorize the direct payment to you of any sum I now or hereafter owe you, by my attorney out of the proceeds of any settlement of my case, and/or by any insurance company obligated to make payment to me or you, based in whole or in part upon the charges made for your services.

3. In the event any insurance company obligated, by contractual agreement, to make payment to me or to you for the charges made for your services, refuses to make such payment upon demand by you. I herby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent date) and authorize you to prosecute and take action in my name as you see fit and further authorize you to compromise, settle or otherwise receive and claim as you see fit. However, it is understood that until a reasonable effort has been made to collect the sums due from the insurance company or companies contractually obligated, you will refrain from collecting the amounts owed directly from me. I understand that whatever amounts you do not collect from the insurance companies' proceeds, whether it is all or part of what is due, I personally owe and agree to pay to you.

4. In addition to the above, I herby waive the statute of limitations on collection and/or recovery in this State of Utah

5. I further agree that this Authorization and Assignment is irrevocable and ongoing until all monies owed are paid in full.

6. This Authorization and Assignment will be in continual effect until revoked by both parties.

_____ _____

Date Patient/Insured Signature

RECORDS RELEASE

To _____, I herby authorize you to release to _____ any information including the diagnosis and records of treatment or examination rendered to me for all care during the period from _____ to _____.

_____ _____ _____ _____

Date Patient/Insured Signature Date Staff Signature

RELEASE FROM CARE

I, _____ hereby understand that Dr. _____ is releasing me from care, for my accident dated _____, and that I have reached [ ] pre-accident status or [ ] maximum medical improvement. I further understand that all expenses incurred from this accident are my responsibility or the insurance company's and that all expenses incurred after the date below will be my personal responsibility. I will make financial arrangements for payment directly.

Parent Signature _____ Date_____ Staff Signature _____

CLAYTON CHIROPRACTIC CLINIC

Frank J. Clayton, D.C.
Jeffery F. Clayton, D.C.
917 E. Country Hills Drive, Suite 4
South Ogden, Utah 84403
Phone: (801) 621-1668 -- Fax: (866) 723-7266 website- www.claytonchiro.com

FINANCIAL POLICY - GENERAL INSURANCE

This statement was prepared in an effort to avoid any misunderstandings, which may arise regarding my fees and your insurance forms coverage. We try to help you in every way we can to make the processing of your insurance forms as simple as possible.

I urge you to know your insurance coverage. Most insurance companies do not cover office visits unless a definite procedure was done. Also, your insurance company probably has a deductible amount that must be paid by you before the insurance goes into effect, and then the company may only pay a portion (e.g. 80%) of the amount billed. Please remember, it is your insurance. You are the one who has made the agreement with the insurance company, not the Doctor. We will bill your primary insurance company as a courtesy to you. We will also bill your secondary insurance company as a courtesy. It is your responsibility to see that the insurance company pays that part of the bill, which is covered by your policy, within a reasonable length of time. We give your insurance company 60 days to make payment, at that time a finance charge of 1.5% per month or a minimum of $2.00 will be applied to the outstanding balance. You are responsible for keeping your appointments as scheduled. If you are unable to keep an appointment, we require a 24-hour notice. If proper notice is not given, you will be charged a missed appointment fee of $10.00. This fee is not covered by insurance and will be your responsibility.

Payment is expected at the time of service. If you have insurance, usually only 20% of the total charges is expected at the time of service, unless you have a deductible to meet. If your insurance company covers more than that, we will be happy to reimburse you by mail upon receipt of the insurance check. If your insurance company makes no response within 60 days, that balance of the account will be your responsibility to pay in full. Payment may be made to us in the form of cash, check, Visa, MasterCard, or Discover Card. All return checks are subject to a $15.00 service fee.

I, the undersigned, specifically agree to pay all reasonable attorney's fees and court costs in the event legal action is taken to collect on the account. I further agree to pay an additional amount representing forty percent (40%) of the principle balance if the account is referred to a collection agency or attorney or collection. This additional amount is in recognition of the costs associated with said collection action processing. I further agree to pay interest at the rate of one and one-half percent (1 ½%) per month, or eighteen percent (18%) per year.

_____ _____

Patient Signature Date

CLAYTON CHIROPRACTIC CLINIC
917 E. COUNTRY HILLS DRIVE. SUITE 4. • SOUTH OGDEN, UTAH 84403
PHONE: (801) 621-1668 • FAX: (866) 723-7266 WEBSITE- WWW.CLAYTONCHIRO.COM

CONSENT FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing below, you consent to the use and disclosure of your protected health information by your doctor, our staff, and our business associates for treatment, payment and health care operations. For a more detailed description of uses and disclosures for these purposes, please review our Notice of Privacy Practices. You have the right to review our Notice prior to signing this consent.

The terms of this Notice may change. If the terms do change, you may obtain a revised Notice by simply contacting this facility and by requesting a revised Notice. We will also post any revised notice in the office.

You have the right to request that we restrict our uses or disclosures of your protected health information, which we are otherwise permitted to make for treatment, payment and health care operations, although we are not required to agree to these restrictions. However, if we agree to further restrictions, they are binding on us. Finally, you have the right to revoke the consent in writing, except to the extent that we have taken action in reliance on it.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I also give Clayton Chiropractic Clinic consent to use and disclose my protected health information as stated in the Notice of Privacy Practices.

I understand that this form will be placed in my patient chart and maintained for six years. I also understand that I have the right to refuse to sign this acknowledgment.

_____ _____

Patient Name (please print) Date

_____

Signature