KIND CHIROPRACTIC CARE

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at Kind Chiropractic Care, we may use or disclose personal and health related information about you in the following ways:
Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer (if they are or may be responsible for the payment of your services.)
Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, to provide information about alternatives to your present care, or to other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization to this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenue associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:
If we are providing healthcare services to you based on the orders of another healthcare provider.
If we provide healthcare services to you in an emergency.
If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as described in the examples outlined above, will only be made upon your written authorization.

We normally provide information about your healthcare to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your healthcare or about the status of you account. If you would like to receive this

information at an address other than your home or, if you would like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or for as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice, we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person or persons to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to:
Richard Ballard 423-753-8556

If you would like further information about our privacy policies and practices please contact:
Richard Ballard 423-753-8556

This notice is effective as of February 1, 2003. This notice, and any alterations or amendments made here to will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

Name (Printed Please) **Signature** **Date**

If you are a minor, or if you are being represented by another party

Personal Representative Printed | Personal Representative Signature | Date

Description of the authority to act on behalf of the patient.

KIND CHIROPRACTIC CARE
RICHARD L. KIND, D.C.
RICHARD D. BALLARD, D.C.
1102 SUNSET DR
JOHNSON CITY, TENNESSEE
37604

IN CONSIDERATION OF KIND CHIROPRACTIC CARE, RICHARD L. KIND, D.C., AND RICHARD D. BALLARD, D.C., (HEREIN AFTER, "KIND") UNDERTAKING TO TREAT THE UNDERSIGNED PATIENT (HEREIN AFTER, "PATIENT"), PATIENT AGREES TO THE FOLLOWING:

1. *AUTHORIZATION TO RELEASE RECORDS:* KIND IS AUTHORIZED TO RELEASE ANY INFORMATION FROM MY PATIENT RECORDS TO ANY INSURANCE COMPANY, ATTORNEY OR ADJUSTOR IN ORDER TO PROCESS ANY CLAIM FOR REIMBURSEMENT OF CHARGES INCURRED BY ME, OR IN ORDER TO ASSIST SAME IN MAKING ANY CLAIM FOR DAMAGES ON MY BEHALF. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL SUBMISSIONS TO ANY INSURANCE COMPANY.

2. *FINANCIAL AGREEMENT:* UNLESS OTHERWISE AGREED, CHARGES FOR TREATMENT ARE DUE AT THE TIME THE SERVICE IS PROVIDED. AS A COURTESY TO PATIENT, KIND WILL SUBMIT PATIENT'S BILLS TO THE APPROPRIATE INSURANCE COMPANIES, AGENCIES AND/OR ATTORNEYS. HOWEVER, PATIENT IS RESPONSIBLE FOR PAYMENT OF DEDUCTABLES AND PATIENT WILL BE PERSONALLY RESPONSIBLE FOR PAYMENT OF HIS/HER ACCOUNT REGARDLESS OF ANY SETTLEMENT OR BENEFITS OF ANY TYPE PATIENT MAY OR MAY NOT RECEIVE. IN THE EVENT ANY INSURANCE COMPANY MAKES PAYMENT SIRECTLY TO PATIENT, PATIENT AGREES TO PAY HIS/HER ACCOUNT IN FULL WITHIN 72 HOURS OF SUCH PAYMENT. IF PATIENT CHOOSES TO SUSPEND OR TERMINATE HIS/HER CARE, THE BALANCE OF PATIENT'S ACCOUNT SHALL BE IMMEDIATELY DUE AND PAYABLE. A LATE PAYMENT CHARGE OF 1.5% PER MONTH MAY BE APPLIED TO A PAST DUE BALANCE. ADDITIONALLY, IN THE EVENT PATIENT'S ACCOUNT IS TURNED OVER FOR LEGAL PROCEEDINGS, PATIENT SHALL BE RESPONSIBLE FOR ALL COLLECTION COSTS AND ATTORNEY FEES.

3. *ASSIGNMENT OF BENEFITS:* THIS IS A DIRECT ASSIGNMENT OF MY BENEFITS OR PROCEEDS UNDER ANY INSURANCE POLICY, OTHER CONTRACTUAL AGREEMENT, OR TORT CLAIM, TO KIND, TO THE EXTENT OF ANY SUMS I OWE KIND AND ANY SUMS ALLOCATED FOR FUTURE CHIROPRACTIC CARE BY AGREEMENT BETWEEN PATIENT AND THE PAYING PARTY. I FURTHER AGREE TO MAKE ALL DEMANDS I AM REQUIRED TO MAKE IN ORDER TO RECEIVE BENEFITS OR OTHER SUMS DUE ME. I AGREE TO NOTIFY KIND IN THE EVENT I RETAIN AN ATTORNEY IN CONNECTION WITH ANY CLAIMS RELATED TO THE CONDITION FOR WHICH I SEEK TREATMENT. I AUTHORIZE AND INSTRUCT ANY ATTORNEY, INSURANCE COMPANY, OR OTHER PERSON OR ENTITY WHO CONTROLS FUNDS TO WHICH I AM ENTITLED TO PAY KIND ANY SUM I NOW OR HEREAFTER OWE KIND. PATIENT HEREBY AUTHORIZES AND DIRECTS ANY ATTORNEY RECEIVING A COPY OF THIS PATIENT AGREEMENT (HEREIN AFTER, "ATTORNEY") TO PAY DIRECTLY TO KIND SUCH SUMS FROM ANY SETTLEMENT OR JUDGEMENT USED BY THE PATIENT IN CONNECTION WITH ANY LAWSUIT RELATED TO CONDITION FOR WHICH PATIENT IS BEING TREATED, AND INSTRUCTS ATTORNEY TO DOTHE SAME AND TO ALSO PROMPTLY DELIVER A COPY OF THIS PATIENT AGREEMENT TO ANY SUCH SUBSTITUTED OR ADDED ATTORNEY(S). NO PAYMENT TO KIND SHALL EXCEED PATIENT'S INDEBTDNESS TO KIND. IF EXISTING INSURANCE POLICIES OR OTHER CONTRACTUAL AGREEMENTS PROHIBIT DIRECT PAYMENT TO KIND, THEN I HEREBY ALSO INSTRUCT AND SIRECT THE APPROPRIATE INSURANCE COMPANY, ATTORNEY, OR OTHER PERSON OR ENTITY TO MAKE THE CHECK PAYABLE TO ME AND MAIL IT TO KIND AT THE ADDRESS LISTED ABOVE.

4. *POWER OF ATTORNEY TO ENDORSE CHECKS:* PATIENT APPOINTS KIND AND ANY OF ITS DULY AUTHORIZED AGENTS AS AND TO BE PATIENT'S TRUE AND LAWFUL ATTORNEY FOR AND IN THE PATIENT'S NAME, PLACE AND SEALED TO ENDORSE ANY AND ALL CHECKS, DRAFTS OR MONEY ORDERS WHICH ARE MADE PAYABLE TO THE PATIENT ALONE OR TO THE PATIENT AND SAID KIND, WHICH CHECKS, DRAFTS AND MONEY ORDERS ARE TO PAY FOR CHIROPRACTIC SERVICES OR THE LIKE WHICH HAVE BEEN PROVIDED BY KIND AT THE REQUEST OR WITH THE KNOWLEDGE AND APPROVAL OF THE PATIENT AND/OR THE MAKER OF THE CHECK, DRAFT OR MONEY ORDER. THE PATIENT THUS GIVES AND GRANTS UNTO THE SAID KIND AS ATTORNEY THE FULL POWER AND AUTHORITY TO PERFORM EVERY ACT WHATSOEVER NECESSARY TO BE

DONE AS THE PATIENT MIGHT OR COULD DO TO PERSONALLY ENDORSE AND CASH SUCH SAID CKECKS. THE PATIENT DOES HEREBY RATIFY AND CONFIRM ANY AND ALL ACTIONS TAKEN BY THE SAID ATTORNEY IN ACCORDANCE WITH THIS SPECIAL POWER OF ATTORNEY.

IN WITNESS WHEREOF, THE UNDERSIGNED HAVE HEREUNTO SET THEIR HANDS, THIS _________________

DAY OF _____________________, 20_____ **PATIENT'S FULL NAME____________________________________.**

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WITNESS TO PATIENT'S SIGNATURE **PATIENT'S SIGNATURE**