AUTHORIZATION OF CARE

Focus Chiropractic will attempt to identify and diagnose any ailments you may have that may be corrected through massage therapy, chiropractic care, SoftWave TRT, non-surgical spinal decompression, and/or active/passive rehabilitation. If any condition or disease appears out of our scope of practice, we will refer you to an appropriate physician to diagnose and/or treat that condition. The clinical procedures performed are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. The doctor, of course, will not provide specific healthcare if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make known these things which otherwise might not come to the attention of the physician (deformities, illnesses, etc). I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or not, by binding arbitration under the current malpractice terms, which can be obtained by written request. I certify that the information I furnish is true and correct. I know it is a crime to fill out this form with facts that I know are false or to leave out important facts.

I also clearly understand that if I do not follow the Doctor's and/or physician's specific recommendations at this clinic I will not receive the full benefit from these programs, and that if I terminate my care prematurely all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits to be directed to the Doctor and/or physician for all services rendered. I understand that in the event my account goes to collections, I will be responsible for all collections fees.

I understand that I am financially responsible for all fees incurred for the services provided, regardless of any applicable insurance or benefit payments, and I agree to ensure full payment. I authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer, and my attorney to release to such doctor and clinic any and all plan documents, insurance policy, and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize using this signature on all my insurance and/or employee health benefits claim submissions.

This assignment will remain in effect until I revoke it in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

MEDICAL RECORDS RELEASE FORM

In order to provide you with the best care possible, we may share your medical records with your family doctor to let them know the progress you are making with our office.

I permit Focus Chiropractic PLLC to share all medical records with my family doctor.

I understand that this authorization is voluntary and I may refuse to sign it. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form. I understand that information used or disclosed according to the authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state privacy regulations. I understand I may revoke this authorization at any time by notifying the office. I understand that if I revoke this authorization, I must do so in writing, and the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

We understand that health information about you and your health is personal, and we are committed to protecting it. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with specific legal requirements. This notice applies to all of the records of your care generated by this office, whether made by your doctor or others working in this office. This notice will tell you how we may use and disclose your health information. We also describe your rights to the health information we keep about you and our obligations regarding the use and disclosure of your health information.

Upon request, we can provide you with our Notice of Privacy Practices, which provides a more complete description of information uses and disclosures.

OFFICE POLICIES

Cancellation policies

We plan your time with the utmost care and ask that you call to reschedule your appointments with at least 24 hours ' notice.

We understand that plans can change, and sometimes, you may need to cancel a booking. Please call to reschedule your appointments with at least 24 hours notice. We also understand emergencies happen. In an emergency, please notify the office as soon as you know your appointment will be missed. NO-SHOW appointments without prior notice will be charged the full treatment cost.

- The first time you do not reschedule in time is on us.
- The second time, you will be charged $25 to the card on file.
- The full treatment cost will be charged to you the third time or for a no-show without prior notice.

Insurances don't cover any show fees.

Chiropractic Appointment Policy

Our regular chiropractic appointments last 15 minutes. To ensure a smooth experience, please arrive on time and ready for your session. Restrooms and a water fountain are available for your convenience.

We understand that delays can happen. If you anticipate being late, please inform us as soon as possible. Our assistant will do their best to accommodate you. However, please note that if you are significantly late, we reserve the right to reschedule your appointment to respect the time of other patients.

In such cases, a rescheduling or missed appointment fee may apply. Thank you for your understanding and cooperation as we strive to provide the best care for everyone.

By signing below, you acknowledge that you have read the above-listed policies, asked any questions if necessary, and that you acknowledge these policies and will adhere to them.

MEDICARE PATIENTS ONLY - ASSIGNMENT OF BENEFITS

I request that authorized Medicare benefits be paid to me or on my behalf to Focus Chiropractic PLLC for treatment or durable medical equipment and supplies ordered by my physician. I authorize any holder of medical information needed to determine these benefits or the benefits payable for related services for me to release it to the Center for Medicare/Medicaid Services and its agency. I understand that my signature requests that payment be made and authorizes the release of medical information necessary to pay the claim. If 'other insurance' is indicated in item 9 of the HCFA-1500 claim form or elsewhere on the

approved claim form or electronically submitted claims, my signature authorizes releasing the information to the insurer or agency listed. In Medicare-assigned cases, the supplier agrees to accept the charge of determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered items. Coinsurance and the deductible are based upon the charge determination to the Medicare carrier.

By signing below, you acknowledge that you have read the above, asked questions if necessary, and that you understand what it states.

ASSIGNMENT OF BENEFITS/ ERISA AUTHORIZED REPRESENTATIVE FORM

Assignment of Insurance Benefits – Appointment as Legal Authorized Representative

I hereby assign all applicable health insurance benefits and all rights and obligations that I and my dependents have under my health plan to the Provider and The Force Law Firm PC and their affiliated law firms (hereinafter, "My Authorized Representatives"), and I appoint them as my authorized representative with the power to:

✓ File medical claims with the health plan

✓ File appeals and grievances with the health plan

✓ Institute any necessary litigation and/or complaints against my health plan ***naming me as plaintiff in such lawsuits and actions if necessary*** (or me as guardian of the patient if the patient is a minor)

✓ Discuss or divulge any of my personal health information or that of my dependents with any third party, including the health plan

I certify that the health insurance information I provided to the Provider is accurate as of the date set forth below and that I am responsible for keeping it updated. I direct my insurance carrier or its intermediaries to issue payment directly to Elite Healthcare Physical Medicine, LLC. I am aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts and services not covered by my health insurance, including co-payments, co-insurance, and deductibles.

Authorization to Release Information

I hereby authorize My Authorized Representatives to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until I revoke it in writing.

ERISA Authorization

I hereby designate, authorize, and convey to My Authorized Representatives to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act as my Authorized Representative in connection with any claim, correct, or cause of action including litigation against my health plan (even to name me as a plaintiff in such action) that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act as my Authorized

Representative to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right and ability to act as my Authorized Representative with respect to a benefit plan governed by the provisions of ERISA as provided in 29 *C.F.R.* §2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines. I authorize communication with the Provider and his authorized representatives by email. I understand I can revoke this authorization in writing at any time.

A photocopy of this Assignment/Authorization shall be as effective and valid as the original. By signing below, you acknowledge that you have read the above, asked questions if necessary, and understand what it states.

Patient Name (Print) Patient Signature Date

_____ _____

Client Signature Date