HIPPA CONSENT FORM

BRONCO INJURY & CHIROPRACTIC CENTER, INC.

I, _____ give Bronco Injury & Chiropractic Center, INC. authority to use and disclose my health care records for the purpose of diagnosing and providing treatment to me and obtaining payment for health care.

I understand that I have the right to inform Bronco Injury & Chiropractic Center, INC about how I would like my healthcare information to be used or disclosed during my treatment.

I have the right to discontinue my treatment service at Bronco Injury & Chiropractic Center, INC. at any time.

I understand that Bronco Injury & Chiropractic Center, INC will use my health information, including my demographic information and will not share my information with individuals other than my physician, insurance company, or my insurance representative.

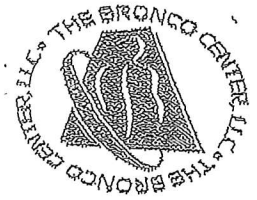
By signing this consent, I agree to allow Bronco Injury & Chiropractic Center, INC to provide Chiropractic care, Hot/Cold Packs, H-Wave, therapeutic exercises and Mechanical traction to me.

_____ _____

(PRINT NAME) (DATE)

_____

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE



AUTHORIZATION
FOR RELEASE OF HEALTH INFORMATION

I,_____, HEREBY
(Patient's Full Name Printed)

AUTHORIZE BRONCO INJURY & CHIROPRACTIC CENTER, TO OBTAIN ANY AND ALL MEDICAL, LEGAL, AND INSURANCE RECORDS NECESSARY TO FACILITATE PAYMENT FOR SERVICES RENDERED. THIS INCLUDES BUT IS NOT LIMITED TO ACCESS TO AUTO INSURANCE CLAIM FILE INFORMATION, ATTORNEY LIEN INFORMATION, AS WELL AS PERSONAL INSURANCE FROM OTHER HEALTH CARE PROVIDERS NEEDED TO RESOLVE COVERAGE AND PAYMENT DISPUTES.

SIGNED_____ DATE_____
(Patient or Representative)

PATIENT'S DATE OF BIRTH: _____

WITNESS_____ DATE_____

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: I have had the following unusual risks of my case explained to me.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and herby give my full consent to treatment.

Printed Name	Signature	Date

WITNESS:

Printed Name	Signature	Date

Patient Financial Responsibility Policy

Bronco Injury & Chiropractic Center, INC. goal is to provide the best service possible. Please call us before your appointment if you need to make special financial arrangements to pay your bill.

1. General
   a. The patient's insurance policy is a contract between the patient and his or her insurance company. However, all charges regardless of the insurance coverage are the patient's responsibility and the patient are ultimately responsible for any unpaid balances. As a courtesy to our patients, BICC bills the patients' insurance and makes every effort to ensure that claims are promptly and correctly processed. BICC also bills patients' secondary insurance when patients provide complete insurance information.
   b. Patient co-pays are expected at the time of service, and any remaining payment is due within 30 days of receiving the first bill from BICC. We accept cash, checks, money orders, debit cards and credit cards (Visa, Master Card, Discover and American Express).
   c. If you can't pay your balance within 30 days, please contact our Billing Office at (248) 644-6272. There are several ways you can pay your bill, including possible payment plans and a Billing Office representative will help find the right one for your financial needs. We will also work with you to determine if you are eligible for financial assistance.
2. Waiver of Co-Pays and Deductibles
   a. It is the policy of this practice to bill all applicable out of pocket amounts and to make reasonable efforts to collect such amounts in accordance with our collection practices and procedures. BICC will not waive co-pays, coinsurance or deductible amounts for insured patients, except in limited circumstances set forth in this Patient Financial Responsibility Policy. Such determinations may be made only after sufficient investigation has been made and it is expected that such waivers will be *rare*.
   b. If BICC does waive co-payments or deductibles for a patient based on the patient's financial status, we will maintain a record of the information upon which we based this decision. Waivers of co-pays and deductibles may also be made after reasonable collection efforts have failed to result in the collection of fees. BJPC will maintain records of what collection efforts have been made for fees waived in these instances.
   c. Under no circumstances will our practice engage in any of the following practices with respect to the waiver of lowering of co-insurance and/or deductibles:
      Waive or lower co-insurance and deductibles that do not meet the requirements outlined in our Policy.
      Advertise, or in any way communicate to the general public that payments from private insurance, Medicare or Medicaid will be accepted as payment in full for health care services provided by our practice, or advertise or otherwise communicate to our patients to the general public that patients will incur no out of pocket expenses.

PATIENT: _____ DATE: _____

NOTICE OF PRIVACY PRACTICES

Our office's Notice of Privacy Practice explains your rights and our policies regarding the protection of your personal health information. It is always kept here posted at the front desk. We are required by federal law to show it to you and get your signature to acknowledge that we have done so. If you would like, you may read it before you sign this or we can give you a copy to take home. Please sign below.

ACKNOWLEDGEMENT OF RECEIPT OF OFFICE PRIVACY POLICY

I acknowledge that _____Bronco Injury & Chiropractic_____ "Notice of Privacy Practices" has been provided to me. I understand that I have the right to review _____Bronco Injury & Chiropractic_____ Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of bills or in the performance of health care operations with _____Bronco Injury & Chiropractic_____ It describes my rights as they concern the limited use of health information including my demographic information collected from me and created or received by my physician. The Notice of Privacy Practices for _____Bronco Injury & Chiropractic_____ is also provided on request at the main administration desk of the practice.

_____Bronco Injury & Chiropractic_____ reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative Date

_____

Name of Patient of Personal Representative

_____

Description of Personal Representative's Authority