OUR FINANCIAL POLICY & HOW IT WORKS FOR YOU

OUR RESPONSIBILITIES

We will:

- ✓ verify your benefits.
- ✓ bill your insurance at your request.
- ✓ provide guidance to minimize your insurance's denial of benefits/charges.
- ✓ respond timely to your requests, questions or issues.

.....

YOUR RESPONSIBILITIES

Whether you are paying cash or using insurance, you are ultimately responsible for your bill.

We request that you:

- ✓ know your insurance coverage.
- ✓ pay any deductibles, coinsurances and/or copayments at the time of your treatment.
- ✓ read your Insurance's Explanation of Benefits and contact us regarding any unpaid claims or discrepancies.
- ✓ give a minimum of 24 hours cancellation notice*

_____ _____

Patient Signature **Date**

_____

Printed Name

***Cancellations with less than 24 hours notice, or no notice, may result in a $50 office visit.**

7075 Elm Street
o: 214.705.1799
f: 214.705.1833

www.TiepermanHealth.com

ASSIGNMENT OF BENEFITS
To
Tieperman Health & Wellness/Lori Tieperman, DC

The undersigned patient and/or responsible party, in addition to continuing personal responsibility and in consideration of treatment or services rendered or to be rendered, assigns to the doctor named above the following rights, powers, and authority:

RELEASE OF INFORMATION: You are authorized to release information concerning any condition and treatment to my insurance company, attorney, or insurance adjuster, for the purpose of processing my claim for benefits and payment of services rendered to me or my dependents.

IRREVOCABLE ASSIGNMENT OF RIGHTS: You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payment, and prosecute and receive penalties, interest, court costs, or other legally compensable amounts owed by an insurance company, in accordance with Article 21.55 of the Texas Insurance code or other applicable insurance or state statutes. I, as the patient and/or responsibility party, further agree to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me/us for treatment rendered by the doctor/facility named above, you are hereby tendered demand to pay in full the bill for services rendered by the doctor/facility named above within sixty (60) days following your receipt of such bill for services to the extent such bills are payable under the terms and conditions of my/our policy for benefit, less any amount which I/we personally owe which are not payable under the terms of the policy. This demand specifically conforms to Article 21.55 of the Texas Insurance code, providing for attorney fees, 18% penalty, court costs, and interest from judgment upon violation.

THIRD PARTY LIABILITY: If patient(s) treatment for injuries are the result of negligence of any third party, then patient(s) grant lien against any recovery from such third party(s), to the extent of the bills for treatment of services, in favor of the doctor/facility named above.

STATUTE OF LIMITATIONS: Patient(s) waive the right to claim any Statute of Limitations regarding claims for services or to be rendered by the doctor/facility named above, in addition to reasonable costs of collection, including attorney fees and court costs, if incurred.

LIMITED POWER OF ATTORNEY: I hereby grant to the doctor/facility named above the power to endorse my name upon checks, drafts, or other negotiable instruments representing payment from the insurance company representing payment for treatment or services rendered by the doctor/facility named above. I agree that the insurance payment representing an amount in excess of the charges rendered will be credited to my account or forwarded to my address upon request in writing to the doctor/facility named above.

TERMINATION OF CARE WAIVER: I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my treating doctor at this clinic, he/she has full and complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time.

A PHOTOCOPY OF THIS INSTRUMENT MAY SERVE AS THE ORIGINAL.

Printed Name: _____ **Date:** _____

Signature: _____

FINANCIAL AGREEMENT
HEALTH INSURANCE

We would like to take a moment to welcome you to Tieperman Health & Wellness and to assure you that you will be receiving the very best care available for your condition. Please read the following to familiarize yourself with Tieperman Health & Wellness's financial policy in handling your medical bills.

Explanation of Insurance Coverage

Most insurance policies cover chiropractic care, but Tieperman Health & Wellness makes no representation that yours does. Insurance policies can differ greatly in terms of deductibles and percentage of coverage for chiropractic care. Because of the variance from one insurance policy to another, we require that you, the patient, be personally responsible for the payment of your deductibles, as well as any unpaid balances to Tieperman Health & Wellness. We will do our best to verify your insurance coverage, and will bill your insurance company(ies) in a timely manner.

Payment

Co-Insurance, deductibles, co-payment, contracted amounts and cash payments are due on each visit. We anticipate payment of the full portion of your health insurance's bill from your insurance carrier. Any unpaid balances will be considered past due thirty (30) days following receipt of your insurance reimbursement. Past due balances may have a one and a half percent (1.5%) interest charge applied per month.

Assignment of Benefits

Included in the admissions packet is an "Assignment of Benefits" form. This form instructs your insurance company to send their payments directly to Tieperman Health & Wellness. Please sign all copies of this form. If your insurance carrier, or other entity reimbursing Tieperman Health & Wellness for your healthcare, sends you payment for services incurred with Tieperman Health & Wellness or Dr. Lori Tieperman, your signature below guarantees you will send or bring the full payment to our business office immediately upon receipt.

Release of Information

If your insurance company, or other entity reimbursing Tieperman Health & Wellness for your healthcare, requires medical reports to document your treatment and progress, your signature below authorizes the release of medical information necessary to process your claim.

Voluntary Termination of Care

If you suspend or terminate your care at any time, your portion of all charges for professional services are immediately due and payable to Tieperman Health & Wellness. All services rendered by this clinic are charged directly to you, and you, ultimately, are personally responsible for payment, regardless of your insurance or other healthcare coverage.*

Please ask our staff any questions regarding this financial agreement to insure you understand Tieperman Health & Wellness's policy prior to signing. If, at any time, you have questions about your care, please don't hesitate to ask.

Once again, welcome to Tieperman Health & Wellness.

I have read and agree to the above.

_____ _____

Patient's Printed Name Date

_____

Patient's Signature

- Prior mutually approved agreements between Tieperman Health & Wellness and payer(s) may amend this "Financial Agreement".

HEALTH CARE AUTHORIZATION

Patient Name: _____

Patient SS#: _____ Date of Birth: _____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES **DR. LORI TIEPERMAN** and/or **TIEPERMAN HEALTH & WELLNESS INC.** TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION (PHI) IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

I give permission to the chiropractic offices of Dr. Lori Tieperman/Tieperman Health & Wellness Inc. to use my address, phone numbers, and clinical records to contact me with birthday cards, holiday related cards, thank you notes, recall cards, informational email, and information about alternative treatments or other health related information.

By signing this form I give the chiropractic offices of Dr. Lori Tieperman/Tieperman Health & Wellness Inc. permission to use and disclose my protected health information in accordance with the directive listed above.

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke the AUTHORIZATION is not effective to the extent that we have provided services or taken in reliance on your authorization.

You may revoke AUTHORIZATION by mailing or hand delivering a written notice to John Tieperman/Tieperman Health & Wellness Inc., the privacy official of the chiropractic offices of Dr. Lori Tieperman/Tieperman Health & Wellness Inc. The written notice must contain the following information:

- Your name, social security number and date of birth;
- A clear statement of your intent to revoke this AUTHORIZATION;
- The date of your request; and your signature.

The revocation is not effective until it is received by the privacy official.

The chiropractic offices of Dr. Lori Tieperman/Tieperman Health & Wellness Inc. requests this AUTHORIZATION for its own use/disclosure of **P**atient **H**ealth **I**nformation. (Minimum necessary standards apply.)

You have the right to refuse to sign this AUTHORIZATION. If you refuse this AUTHORIZATION, the chiropractic offices of Dr. Lori Tieperman/Tieperman Health & Wellness Inc. will not refuse to provide treatment. You have the right to inspect or copy the **P**atient **H**ealth **I**nformation to be used/disclosed.

A COPY OF THIS AUTHORIZATION MAY BE PROVIDED FOR YOU

Printed Patient Name: _____

Signature: _____ Date: _____

7075 Elm Street, Frisco, TX 75034
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Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. If services are paid in full by cash you may restrict that information to any insurer for purposes other than for treatment.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have a right to request that we amend your protected health information. Please be advised, however, that we may not be required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of certain disclosures of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

This office reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, we are required by law to comply with this Notice.

Complaints

Complaints about your privacy rights, or how Tieperman Health & Wellness has handled your health information should be directed to John Tieperman by calling this office at (214) 705-1799. If John Tieperman is not available, you may make an appointment for a personal conference in person or by telephone within two (2) working days.
If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

FOR ADDITIONAL INFORMATION ABOUT YOUR PRIVACY, PLEASE VISIT:

www.hcfa.gov/medicaid/hipaa

TIEPERMAN HEALTH & WELLNESS

NOTICE OF PRIVACY PRACTICES

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

Tieperman Health & Wellness *is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.*

Disclosure of your Health Care Information

Treatment

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

"It is our policy to provide a chiropractor, authorized by Tieperman Health & Wellness, to provide assessment and/or treatment to our patients, without advanced notice, in the event of your Chiropractic provider's absence due to vacation, sickness, or other emergency situation."

Payment

We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

If payment is not made as arranged, our office may utilize an outside collection agency, credit reporting agency or other means of collecting outstanding debt. The designated collection agency or authority may review your file containing protected health care information.

Workers' Compensation

If applicable, we may disclose your health information as necessary to comply with state Workers' Compensation Laws.

Emergencies

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care, about your medical condition or in the event of an emergency or of your death.

Public Health

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.

Judicial and Administrative Proceedings

We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement

We may disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes.

Deceased Persons

We may disclose your health information to coroners or medical examiners.

Organ Donation & Research

Though highly unlikely or probable we must inform you that there may a need to release your health information to organizations involved in procuring, banking or transplanting organs and tissues, or to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies

We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing & Other Communication

We may contact you for marketing purposes or fundraising purposes, as described below: satisfaction surveys, special offers, needs analysis, etc.

"As a courtesy to our patients, it is our policy to call your home, or text your cell phone, on the evening prior to your schedule appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No protected health information will be disclosed during this call other than the date, time and location of your scheduled appointment and a request to call our office if you need to cancel or reschedule your appointment."

INFORMED CONSENT - CONSENT TO TREAT

Please read the following information and sign below. By signing this form you are agreeing to treatment and are informed of all risks involved with Chiropractic care. If you have any questions or concerns prior to signing or being treated, feel free to ask the doctor.

Every type of health care is associated with some risk of a potential problem. This includes chiropractic health care. We want you to be informed about potential problems associated with chiropractic health care before consenting to treatment. This is called informed consent.

Chiropractic adjustments are the moving of bones with the doctor's hands or with the use of a machine. Frequently, adjustments create a "pop" or "click" sound/sensation in the area being treated.

In the office we use trained staff personnel to assist the doctor with portions of your consultation, exam, x-rays, physical therapy application, traction, massage therapy, exercise instruction, etc. Occasionally when your doctor is unavailable, another clinic doctor will treat you on that day.

Stroke: Stroke is the most serious problem associated with chiropractic adjustments, but the least likely to happen. Stroke means that a portion of the brain does not receive enough oxygen from the blood stream. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death. Chiropractic adjustments have been associated with strokes that arise from the vertebral artery only. This is because the vertebral artery is actually found inside the neck vertebrae. The adjustment that is related to vertebral artery stroke is called the "extension-rotation-thrust atlas adjustment." We do not do this type of adjustment on patients. Other types of neck adjustments may also potentially be related to the vertebral artery strokes, but no one is certain. The most recent studies (Journal of the CCA, Vol 37 No.2, June 1993) estimate that the incident of this type of stroke is 1 per every 3,000,000 upper neck adjustments. This means that an average chiropractic would have to be in practice for hundreds of years before they would statistically be associated with a single patient stroke.

Disc Herniation: Disc herniations that create pressure on the spinal nerve of the spinal cord are frequently successfully treated by chiropractors and chiropractic adjustments, traction, etc. This includes both neck and back. Yet, occasionally chiropractic treatment will aggravate the problem and rarely surgery may become necessary for correction. Rarely chiropractic adjustments may also cause a disc problem if the disc is in a weakened condition. These problems occur so rarely that there are no available statistics to quantify their probability.

Soft Tissue Injury: Soft tissue primarily refers to the muscle and ligaments. Muscles move bones and ligaments limit joint movement. Rarely a chiropractic adjustment, traction, massage therapy, etc. will crack a rib bone, and this is referred to as a fracture. This only occurs on patients that have weakened bones from a condition known as osteoporosis. Osteoporosis can be noted on your x-rays. We adjust all patients very carefully, and especially those who have osteoporosis on their x-rays. These problems occur so rarely that there are no available statistics to quantify their probability.

Physical Therapy Burns: Some of the machines we use generate heat. We also use both heat and ice, and recommend them for home care on occasion. Everyone's skin has different sensitivities to these modalities, and rarely, either heat or ice can burn or irritate the skin. The results are a temporary increase in skin pain, and there may even be some blistering of the skin. These problems occur so rarely that there are no available statistics to quantify their probability.

Soreness: It is common for chiropractic adjustment, traction, massage therapy, exercise, etc., to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic changes. It is not dangerous, but please do tell your doctor about it.

Other Problems: There may be other problems or complications that might arise from chiropractic treatment other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment.

Chiropractic is a system of health care delivery, and therefore, as with any health care delivery system we cannot promise a cure for any symptom, disease, or condition as a result of treatment in the clinic. We will always give you our best care, and if results are not acceptable, we will refer you to another provider who we feel will assist your situation.

_____ _____

Patient's Name (Printed) Date

_____

Patient's Signature

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Patient Name:_____ Date of Birth:_____

I have received a copy of Tieperman Health & Wellness' (TH&W) Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practices legal duties with respect to my protected health information. The Notice includes:

- A statement that TH&W is required by law to protect the privacy of protected health information.
- A statement that TH&W is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that TH&W is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the purposes for which TH&W is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of other uses and disclosures that will be made only with my written authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
    - The right to complain to TH&W and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
    - The right to request restrictions on certain uses and disclosures of my protected health information, and that TH&W is not required to agree to a requested restriction.
    - The right to receive confidential communications of protected health information.
    - The right to inspect and copy protected health information.
    - The right to amend protected health information.
    - The right to receive an accounting of disclosures of protected health information.
    - The right to obtain a paper copy of the Notice of Privacy Practices from TH&W upon request.

TH&W reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that TH&W maintains. I understand that I can obtain TH&W's current Notice of Privacy Practice upon request.

Signature:_____ Date:_____

Relationship to patient (if signed by legal guardian/ parent/ personal representative of patient)_____

PATIENT INFORMATION

PATIENT INFORMATION

Name: _____

Address: _____ _____

City: _____ St: _____ Zip: _____

Birthday: _____ Age: _____ | Male | Female |

Social Security#: _____

Occupation: _____

Employer: _____

Parent's Name(if a minor): _____

Single	Married	Divorced	Widowed	Separated

Spouse's Name: _____

# of Children: _____ Name(s): _____

How did you hear about us? | Doctor | Lawyer | Search Engine | TH&W Website | Insurance | Other |

Referral ID/Info: _____

ACCIDENT INFORMATION

Is your condition due to an accident? | Yes | | No |

Type of accident? | Auto | Work | Home | Other: _____

To whom have you reported the accident?

Insurance	Workers Comp	Employer	Attorney	Other

Attorney Name (If applicable) _____

INSURANCE

Who is responsible for this account? _____

Relationship to patient _____

Insurance company _____

Insurance ID number _____

Group / Claim number _____

Is patient covered by additional insurance | Yes | | No |

Insurance company _____

Subscriber # & Name _____

Birthdate _____ Group# _____

Please present insurance card(s) so we can copy your file.

CONTACT INFORMATION

Home phone _____

Cell phone _____

Work Phone _____ Ext _____

Email _____

Best way to reach you: | Cell | Work | Email | Text | Mail |

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone _____ Cell _____

PATIENT CONDITION

What is your major symptom/problem? _____

When did your symptoms begin? _____

Have you had this problem before? _____

Is your condition getting progressively worse? | Yes | | No |

Is this problem: | constant | comes & goes |

How does it Feel?

Burning	Sharp	Shooting	Dull	Aching	Stiff
Tingling	Throbbing	Swelling	Other: _____		

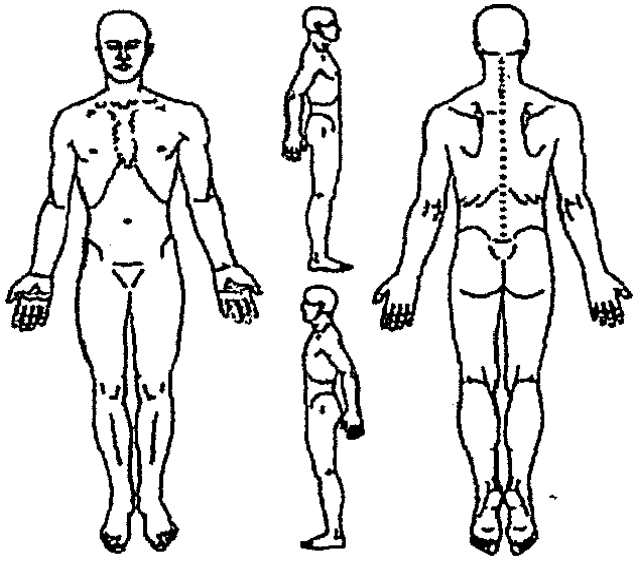
Circle below the severity of your pain on a scale of 0 to 10:

No Pain > | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | < **Severe Pain**

What makes your condition better? _____

What makes your condition worse?

Does it interfere with your: | Work | Sleep | Daily Rountine | Recreation |



Activities/movements that are painful to perform:

Sitting	Standing	Walking	Bending	Lying Down	Driving	Reading	Getting Up

TIEPERMAN HEALTH WELLNESS

7075 Elm St ... Frisco, Tx 75034

(214) 705-1799

PATIENT INFORMATION

HEALTH HISTORY

What other treatments have you had for this condition? _____

☐ Chiropractic ☐ Orthopedic ☐ Neurologist ☐ Physical Therapy ☐ Medication ☐ Surgery

Name of other doctors who have treated you for this condition _____

Describe the other doctor's treatment for your condition _____

Previous Chiropractic care? Yes No Date _____ Local Out of state What state if out?

Date of Last: Physical Exam: _____ MRI: _____ Spinal X-Ray: _____

Spinal Exam: _____ Dental x-ray: _____ CT- Scan: _____

List any Medications you are taking _____

Vitamins / Herbs / Minerals _____

Females: Are you Pregnant Yes No Beginning of last menstrual cycle _____

Check any of the following conditions you have had:

☐ AIDS/HIV	☐ Ear ringing	☐ Neck pain
☐ Allergies	☐ Epilepsy	☐ Osteoporosis
☐ Anxiety/Depression	☐ Headaches	☐ Poor circulation
☐ Arm/shoulder pain	☐ Headaches - Migraine	☐ Prostate problems
☐ Arthritis	☐ Heart Disease	☐ Rheumatoid Arthritis
☐ Asthma	☐ Hemorrhoids	☐ Sciatica
☐ Bladder problems	☐ Herniated disk	☐ Shingles
☐ Cancer	☐ High blood pressure	☐ Sinus infection
☐ Chronic fatigue	☐ Insomnia	☐ Stroke
☐ Deafness	☐ Irregular cycle	☐ Thyroid problems
☐ Diabetes	☐ Kidney problems	☐ TMJ
☐ Digestion problems	☐ Leg pain	☐ Venereal disease
☐ Earache	☐ Low back pain	☐ Vertigo/Dizziness

STRESSORS		**EXERCISE**
☐ Smoking	Packs/day _____	☐ None
☐ Alcohol	Drinks/week _____	☐ Moderate
☐ Coffee/ Caffeine Drinks	Cups/day _____	☐ Daily
☐ High stress levels	Reason _____	☐ Heavy

Have you ever had any:	**Description**	**Date**
Automobile accidents:		
Surgeries:		
Broken bones:		
Falls/Head injuries		

AUTHORIZATION

Insurance verification and authorization is not a guarantee of payment. I understand that I may be responsible for any balance that is not paid by insurance. I authorize Tieperman Health & Wellness Inc./Lori Tieperman, D.C. to release any information regarding my treatment to any insurance company in their effort to receive reimbursement for services provided. I authorize the use of this signature on all insurance submisions.

Signature _____ Date _____ Parent (if patient is a minor) _____

TIEPERMAN HEALTH WELLNESS
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