PATIENT NAME: DATE:

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 California and federal law, and not by a lawsuit or resort to court process except as California and federal law provide 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 healthcare 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 healthcare provider and/or other licensed healthcare 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 healthcare provider, including those working at the healthcare 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 healthcare provider, and/or the healthcare 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 equal 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 the California Medical Injury Compensation Reform Act shall apply to disputes within this arbitration agreement, including, but not limited to, sections establishing the right to introduce evidence of any amount payable as a benefit to the patient as allowed by law (Civil Code 3333.1), the limitation on recovery for non-economic losses (Civil Code 3333.2), and the right to have a judgment for future damages conformed to periodic payments (CCP 667.7). The parties further agree that, where not in conflict with this agreement, the Arbitration Rules of ADR Services, Inc. shall govern any arbitration conducted pursuant to this Arbitration Agreement. A copy of the ADR Services rules are available on its website at www.adrservices.com or by calling 213-683-1600 to request a copy of the rules.

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 healthcare 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.

Both parties agree that this agreement may be electronically signed, and that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

Patient Name (print): _____ Signature: _____ Date: _____

Parent or Guardian (print): _____ Signature: _____ Date: _____

Office Name: _____ Signature: _____ Date: _____

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.

Both parties agree that this agreement may be electronically signed, and that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: David C Ressler, D.C. Signature: _____ Date: _____

I also attest under penalty of perjury that I have verbally informed the patient of the material risks of the proposed chiropractic care.

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE

Acknowledgement of Receipt of NPP

Ressler Chiropractic Inc

HIPAA

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement. In refusing we *may not be allowed* to process your insurance claims.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

_____ _____ _____

Please ***print*** name of Patient Please ***sign*** for Patient Date

_____ _____

Legal Representative / Guardian Relationship

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment _____

I could not communicate with the patient _____

The patient refused to sign _____

The patient was unable to sign because _____

Other (please describe) _____

_____ _____

Signature of Privacy Officer Date

FINANCIAL POLICY

RESSLER CHIROPRACTIC INC.

____

Patient's Name

Thank you for choosing us as your health care providers. We are committed to your treatment being successful. The following is our Financial Policy, which we require you read and sign prior to seeing the doctor.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE

WE ACCEPT CASH
WE ACCEPT CHECKS (our returned check/NSF is charge is $30)
WE ACCEPT MASTERCARD/VISA/AMEX/DEBIT (CARD)
WE ACCEPT HRAs/HSAs/FSAs

If you are here due to injuries from work or an auto accident, please complete the appropriate accompanying form and return it to the front desk with this Financial Policy.

Regarding Your Insurance
Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Your portion (co-pays, co-insurance, and deductibles) is due at the time of treatment. We agree to await the balance of payment of claims submitted by us directly to your insurance company after your portion has been paid.

Verifying Coverage
If as a courtesy to you we have verified coverage, it remains your responsibility to confirm your coverage. All services/products rendered/purchased remain your sole responsibility. Payment in full is our policy at your first visit if we are not able to verify coverage before. If your insurance company has not paid, or there is a coverage discrepancy on a bill after 45 days, the balance of that bill will automatically be considered your responsibility and billed to you or charged to your CARD on file.

"Reasonable and Necessary"/"Medically Necessary"/"Usual and Customary" Rates/Charges
Please be aware that some of the services provided may be non-covered services. Although we provide only those services that we believe are necessary for the best possible results, some of these charges may not be considered "reasonable and necessary" for coverage by Medicare and/or other medical insurance. You are responsible for payment regardless of any insurance company's arbitrary determination of "usual and customary" rates.

Regarding Your Credit/Charge/Debit (CARD)
When you give us your CARD we keep it stored in an electronic vault provided by our credit card vendor. Your information is protected not only by the CCA but also HIPAA and is more secure than your bank information. Understanding this, you agree and give us permission to charge your CARD for the following reasons:

- Your portion not collected from you at the beginning of your visit
- No-show fees, Late-payment fees, and Interest charges if applicable
- Insurance coverage discrepancies that are not resolved within 45 days of the date of service
- Outstanding balances greater than 45 days past due

<u>Late Payment Fee/ Interest Charge</u>
As healthcare providers, we may provide interest-free payment agreements in compassion for our patients. If, however for any reason, you have not made an agreed payment, a $30 late-payment fee will be added to your account on the first of the following month. Additionally an interest charge of 20% APR will be charged to your account from that time forward until the account is paid in full.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

I have read, understand, and agree to this Financial Policy.

______________________________________ ________________________

Patient or Responsible Party Date

No-Surprises Billing Protection Form

Patient name: _____

Out-of-network provider (OON): **Ressler Chiropractic Inc** **Tax ID: 45-1603105** **NPI: 1740574847**

Date patient was given written notice that office is OON: _____

The purpose of this document is to let you know about your protections from unexpected medical bills. It also asks whether you would like to give up those protections and pay more for out-of-network care.

IMPORTANT: You are not required to sign this form and should not sign it if you did not have a choice of health care provider when you received care. You can choose to get care from a provider or facility in your health plan's network, which may cost you less.

If you would like assistance with this document, ask your provider or a patient advocate.

You're getting this notice because Ressler Chiropractic Inc is not in your health plan's network. This means Ressler Chiropractic Inc does not have an agreement with your plan.

Getting care from this office could cost you more.

If your plan covers the item or service you are receiving, federal law protects you from higher bills:

- When you get emergency care from out-of-network providers and facilities, or
- When an out-of-network provider treats you at an in-network hospital or ambulatory surgical center without your knowledge or consent.
- When actual costs from out-of-network provider are more than $400 higher than estimated.

Ask your health care provider or patient advocate if you need help knowing if these protections apply to you.

If you sign this form, you may pay more because:

- You are giving up your protections under the law and agreeing to the OON cost.
- You may owe the full costs billed for items and services received.
- Your health plan may not count any of the amount you pay towards your deductible and out-of-pocket limit. Contact your health plan for more information.

You **should not** sign this form if you **did not** have a choice of providers when receiving care. For example, if a doctor was assigned to you with no opportunity to make a change.

Before deciding whether to sign this form, you can contact your health plan to find an in-network provider or facility. If there isn't one, your health plan might work out an agreement with this provider or facility, or another one.

See the next page for your cost estimate.

Estimate of what you could pay

Patient name: _____

Out-of-network provider(s)or facility name: **Ressler Chiropractic Inc Tax ID: 45-1603105 NPI: 1740574847**

Total cost estimate of what you may be asked to pay: _____

►**Review your detailed estimate.** See Page 3 for a cost estimate for each item or service you'll get.

►**Call your health plan.** Your plan may have better information about how much you will be asked to pay. You also can ask about what's covered under your plan and your provider options.

►**Questions about this notice and estimate?** Call 650-583-4080 to speak with Dr. Ressler

►**Questions about your rights?** Contact Health and Human Services 800-985-3059

Prior authorization or other care management limitations

Except in an emergency, your health plan may require prior authorization (or other limitations) for certain items and services. This means you may need your plan's approval of an item or service before you get them. If prior authorization is required, ask your health plan about what information is necessary to get coverage.

Understanding your options
You may be able to get the items or services described in this notice from these providers who are in-network with your health plan:

More information about your rights and protections
Visit No Surprises Act | CMS https://www.cms.gov/nosurprises for more information about your rights under federal law.

By signing, I give up my federal consumer protections and agree to pay more for out-of-network care.
With my signature, I am saying that I agree to get the items or services from **Ressler Chiropractic Inc.**
With my signature, I acknowledge that I am consenting of my own free will and am not being coerced or pressured. I also understand that:

- I'm giving up some consumer billing protections under federal law.
- I may get a bill for the full charges for these items and services, or I may have to pay out-of-network cost-sharing under my health plan.
- I was given a written notice explaining that my provider or facility isn't in my health plan's network, the estimated cost of services, and what I may owe if I agree to be treated by this provider or facility.
- I got the notice either on paper or electronically, consistent with my choice.
- I fully and completely understand that some or all amounts I pay might not count toward my health plan's deductible or out-of-pocket limit.
- I can end this agreement by notifying the provider or facility in writing before getting services.

IMPORTANT: You **don't** have to sign this form. But if you don't sign, this facility will not treat you. You can choose to get care from a provider or facility in your health plan's network.

_____ _____
Patient's signature Guardian/authorized representative's signature

_____ _____
Print name of patient Print name of guardian/authorized representative

_____ _____
Date of signature Date of signature

Take a picture and/or keep a copy of this form.
It contains important information about your rights and protections.