

Optimal Health Institute Financial Policy

In the interest of good health care practice, it is desirable to establish a policy to avoid misunderstandings. Our primary responsibility is to help our patients experience good health, and we wish to spend our time and energy toward that end. Therefore we wish to clarify the following:

Patients who reserve an appointment with **Optimal Health Institute** and fail to keep that appointment may be subject to a minimum appointment charge of \$25.00. To avoid this charge, patients should cancel appointments that they will not be able to attend prior to the reserved time.

We will prepare and deliver a medical claim for all other costs of your care if you present your current health insurance card during your office visit. This preparation service is not a guarantee that we have a contractual relationship with your insurance plan. Nor can we guarantee that your specific insurance policy covers the services that we have provided.

You should hear from your insurance company within 30 days of your treatment. If you do not, or you believe that your insurance company has not paid your medical cost correctly, you should contact your insurance company to negotiate a solution. We do not have a way to access the terms and conditions of your insurance policy and are therefore unable to speak on your behalf to your insurance company about contract disputes that you have.

You will receive a statement from us monthly. This will include all charges that are your responsibility as well as charges that your insurance company has not paid. Your payment to us is due to us within 10 days of the statement date.

We do not have a commercial financing or collection service. You will be asked to pay for services in advance; if you do not keep your account current you may be discharged from care and/or have your account turned over to a professional credit agency in the event that your account becomes delinquent. It is not our intention to cause undue hardship, however, we must collect our receivables as efficiently as possible in order to continue our service to the community.

To date you have not provided proof of insurance or we were unable to verify eligibility and coverage for Therapy services and are therefore, responsible for the cost associated with any services received at Optimal Health Institute.

I have read and accept the credit policy terms outlined above. I agree that in the event additional costs and/or fees are incurred in connection with the collection of my account; I will pay all such costs and fees including collection costs, attorney fees and all other court costs.

I hereby authorize my insurance benefits to be paid directly to Optimal Health Institute. I also authorize Optimal Health Institute to release any information required by my insurance company.

PERMISSION TO TREAT: I hereby give Optimal Health Institute permission to evaluate and treat the below named patient.

Print Name: _____

Signature: _____ Date: _____

Questions or Concerns please call Optimal Health Institute billing office at 800-511-0729



1415 W. Lake St.
Addison, IL 60101
630-705-1950
630-705-1980 fax

Date: _____

Patient Information (please fill out *completely*)

Patient Full Name: _____

E-Mail: _____ May we contact you via e-mail: Y N Do you live alone? Y N

How did you hear about our clinic? Doctor Newspaper Phonebook Friend Family Member Walk-In Other
If other please specify: _____

Chief Complaints (why you are here today): 1. _____

2. _____ 3. _____

Have you experienced these before? Y N When did you first experience these this time? _____ Last time? _____

Currently Working: Y N number of days/week _____ number of hours/day _____ Work limitations: Y N Pain worse AM PM

Are your present problems due to an injury? No Yes On the Job Auto Accident Personal Injury Other _____

Have you made a report of your accident? N/A No Yes To employer Auto Carrier Other _____

Have you retained an attorney? No Yes Name _____

Do you have a Pacemaker? Y N Wear a hearing Aide? Y N What is your dominant hand? Right Left

Please list all allergies _____

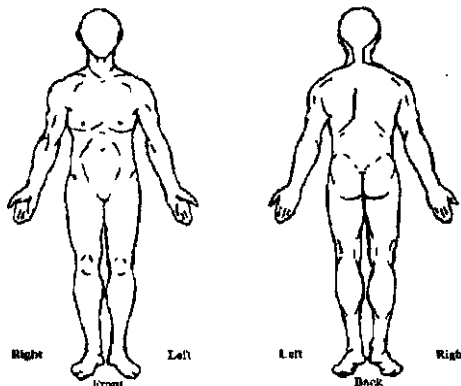
PAST MEDICAL HISTORY/OPPERATIONS: List dates and procedures. _____

CURRENT MEDICATIONS: (BOTH PRESCRIBED AND OVER-THE-COUNTER, INCLUDING VITAMINS WITH DOSAGE INFORMATION)

HABITS: Smoking _____ packs/day Alcohol _____ drinks/week Caffeine _____ cups/day EXERCISE: None Moderate Daily

Any other medical conditions: _____

Please make an X on the area/s where you are experiencing pain:



Summary of our Notice of Privacy Practices

Optimal Health Institute

Effective Date: April 14, 2003

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

Please review the full Notice of Privacy Practices (NPP) which is attached. If you have any questions about this notice, please contact James E. Bilotti, Director of Human Resources & Risk Management at 262-657-0222.

WHO WILL FOLLOW THIS NOTICE

- Optimal Health Institute

This notice describes our privacy practices. All these entities, sites, and locations follow the terms of this notice. In addition, these entities, sites, and locations may share health information with each other for treatment, payment, or health care operations purposes described in this notice.

OUR PLEDGE REGARDING HEALTH INFORMATION

We understand that health information about you and your health care is personal. We are committed to protecting health information about you. 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 certain legal requirements. This notice applies to all of the records of your care generated by this health care practice, whether made by your personal physical therapist or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- make sure that health information that identifies you is kept private
- give you this notice of our legal duties and privacy practice with respect to health information about you; and
- follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose health information. By coming for care, you give us the right to use your information for treatment, to get reimbursed for your care, and to operate our organization.

There are also various ways in which we may use or disclose your information:

- To allow oversight of the quality of the healthcare we provide
- To allow workers' compensation claims
- As required by subpoena in lawsuits and disputes
- Various uses as required by law or to avert a serious threat to health or safety

The full details for all these uses are contained in the full NPP.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

- Right to inspect and copy
- Right to amend
- Right to an accounting of disclosures
- Right to request restriction
- Right to request confidential communications
- Right to a paper copy of this notice

Information on how to exercise these rights can be seen in the NPP or can be obtained from James E. Bilotti, Director of Human Resources & Risk Management at 262-657-0222.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our facility. The notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you register for treatment or health care services, we will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact James E. Bilotti, Director of Human Resources & Risk Management. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.



I, _____ have received the Notice of Privacy Practices from Optimal Health Institute.

Patient Signature: _____ Date: _____

In lieu of patient signature, _____ a staff member of Optimal Health Institute, state that _____ has been given our Current Notice of Privacy Practices.

Signature: _____ Date: _____

Acknowledgement of Receipt of Notice of Privacy Practices