



CLINIC POLICIES

One of our primary goals is to resolve your health issue(s) by understanding the cause of your problem(s), rather than just treat your symptoms. The success of this goal depends in part on your ability to follow through with instructions and the necessary changes to be made between visits. It is also important for you to keep the scheduling of your next office visit as close as possible to the recommended time of your return. If a follow-up appointment must be canceled, no charge will be made if notice is given at least 24 hours in advance. If this is not done, a visit fee, at treatment visit cost, will be charged according to visit type scheduled. Payment of this fee is to be provided before your treatment with the doctor resumes.

FEES, BILLING, & PAYMENT:

Our fee per treatment is \$65 for 15 minutes and \$55 per additional 15 minutes when needed. Lab work and/or other materials (such as nutritional supplements) are charged additionally as needed. Initial consultation and exam visits average 45 minutes and the fee is \$280 which includes a detailed Report of Findings (ROF) during your follow-up visit. Your follow up visit will be 45 minutes in length which again includes your ROF and treatment. If your visit requires more treatment and therefore lasts longer than the scheduled 15 minutes or 30 minutes, you will be charged \$15 per additional 5 minutes. I understand that Integrative Health & Wellness Center Inc. is not responsible for any injury that may occur while utilizing steam sauna, ozone, and/or oxygen therapy.

Payment is due at the end of each examination and/or treatment visit. You are solely responsible for the charges you incur in said clinic. Integrative Health & Wellness Center Inc. and those employed by it, will not file, send documentation or generate additional requested documentation beyond previously completed treatment notes to your insurance and/or health saving account company. Patients 65 and older will not receive traditional Chiropractic treatment i.e. spinal manipulation at this clinic but will receive nerve receptor therapy in order to correct spinal malposition. The doctors of Integrative Health & Wellness Center Inc. (IHWC) are not participating providers of any insurance plan.

All fees are subject to change. Integrative Health & Wellness Center Inc. and staff will to their best to notify all patients of such changes when and if they occur.

WORKERS COMPENSATION AND PERSONAL INJURY CASES

We DO NOT accept Workers Compensation or Personal Injury Insurance as a form of payment in this clinic. If you have been injured and are planning on utilizing this form of insurance to cover your visit payments, as a courtesy, we will provide you with three local Chiropractic clinic phone numbers and their respective addresses that do accept the above stated insurance for payment.

If you file a workers' compensation and/or personal injury claim while under the care of either Dr. Cullyn Consales or Dr. Sara Vivona we will again provide you with three local chiropractic office phone numbers and their respective addresses for treatment and discontinue treatment within this office until the claim is closed. At that time, you may then resume Chiropractic / Applied Kinesiology treatment within this office.

PERMISSION AND AUTHORIZATION OF TREATMENT

I specifically authorize the Doctors at IHWC to perform a nutritional and structural health analysis and to develop a natural, complementary health improvement program for me which may include dietary guidelines, nutritional supplements, functional neurology treatments, cold laser, ozone, oxygen, sauna therapy, etc. in order to assist me in improving my health, and not for the treatment, or "cure" of any disease.

I understand that this is a safe, non-invasive, natural method of analyzing the body's physical and nutritional and functional needs, and that deficiencies or imbalance in these areas could cause or contribute to various health problems.

I understand that the methods utilized in this clinic are not for "diagnosing" or "treating" of any disease including conditions of cancer, AIDS, infections, or other medical conditions, and that these are not being tested for or treated.

No promise or guarantee has been made regarding the results of natural health, nutritional, or dietary programs recommended, but rather I understand that the care provided in this clinic is a means by which the body's posture, dysfunctional state, and natural reflexes, can be used as an aid to determining possible nutritional and structural imbalances, so that safe natural programs can be developed for the purpose of bringing about a more optimum state of health. This permission authorization applies to subsequent visits and consultations.

EMERGENCIES:

In case of emergency, please call the office (724) 205-6260 and leave a message or email us at staff@ihwcenter.com. Your call or email will be returned as soon as possible. In the event that we do not return your call in a timely manner, you should go to your local emergency room or call 911.

NOTICE OF PRIVACY PRACTICES

PATIENT'S RIGHTS AND RESPONSIBILITIES TO PRIVACY

Dr. Cullyn Consales, Dr. Sara Vivona, and staff respect your privacy and will do everything possible to protect your privacy. This Notice of Privacy Practices describe how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present or future physical or mental health or condition and related health care services.

ELECTRONIC PERSONAL HEALTH INFORMATION SUBMISSION POLICY

As a convenience and courtesy to our patients, IHWC has provided all patient intake forms for you here. Although only the doctors and staff of IHWC have access to all information regarding PHI (Personal Health Information) submitted the materials are not encrypted in any manner. Therefore, you should assume that any information you send to or request from IHWC via website, social media, or via email, staff@ihwcenter.com, drcullyn@ihwcenter.com, or drsara@ihwcenter.com are unsecured and your PHI may be breached. If emailing your PHI is a concern you may contact the staff at (724) 205-6260.

The doctors of IHWC request that you sign this form as an understanding that your PHI may not be secure during transmission or retrieval (in either direction) yet you accept this risk and choose to correspond via internet submission and/or email. Although IHWC takes steps to ensure that you are the intended recipient of any personal requested information, we can make no guarantees.

USES AND DISCLOSURES OF PHI

Your protected health information may be used and disclosed by your physician, the office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice and any other use required by law.

TREATMENT: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This included the coordination or management of your health care with a third party. For example, we would disclose protected health information (PHI), as necessary, to a home health agent that provides care to your or to a physician whom you have been referred to ensure that they physician has the necessary information to diagnose or treat you.

PAYMENT: Your PHI will be used, as needed, to obtain payment for your health care services.

HEALTH CARE OPERATIONS: We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to: quality assessment activities, employee review activities, training of Chiropractic students, licensing, etc. For example, we may disclose your PHI to a chiropractic student that may see patients in our office. We may also call you by name in the waiting room when your physician is ready to see you. We may

use or disclose your PHI as necessary to contact you to remind you for an appointment. We may use or disclose your PHI in the following situations without your authorization. These situations include: as Required by Law, Public Health issuers as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroner, Funeral Directors, Organ Donation, Research, Criminal Activity, Military Activity and National Security, Worker's Compensation, Inmates-required uses and disclosures. Under the law, we must make disclosure to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance of Section 164.500

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES: Will be made with your consent, authorization or opportunity to object unless required by law. You may also revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use of disclosure indicated in the authorization.

YOUR RIGHTS

The following is a statement of your rights with respect to your PHI.

You have the right to inspect and copy your PHI. There is a charge for copying. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation, or in a civil, criminal or administrative action or proceeding, and the PHI that is subject to laws that prohibit access to the PHI.

You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or health care operations. You may also require that any part of your PHI not be disclosed to family members or friends who may be involved in your care for notification purposes as described in the notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another health care professional. We however, do not release your medical information without your prior knowledge in any way other than for your continued care or billing purposes. If so, we would have you sign an additional form.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to have your physician amend your PHI. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

COMPLAINTS

You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy officer. We will not retaliate against you for filing a complaint.

LEGAL

Our primary responsibility is to provide quality, responsive patient care. Due to the time-consuming demands resulting from legal care involvement, it is the policy of IHWC to not accept the care of a patient requiring this assistance. Patients who require clinical advice for legal purposes will be referred to physicians who are prepared to provide litigation support.

PLEASE SIGN BELOW INDICATING THAT YOU HAVE READ, UNDERSTAND, AND FULLY AGREE TO THE ENTIRE CONTENTS OF THESE PAGES, INCLUDING THE 24-HOUR CANCELLATION FEE CHARGE POLICY.

NAME (print): _____

SIGNATURE: _____ DATE: _____