Consents / Signatures:

CONSENT TO TREAT: ***Date:*** _____

I voluntarily consent to receive healthcare services from **LifeArts Integrated Health Center, PC** and **LifeArts Medical, LLC**, including services provided by their providers, employees, and associates, as deemed medically appropriate by my provider. I understand that my care may include, but is not limited to, medical evaluations, examinations, diagnostic testing, and treatment.

I understand that digital photographs may be taken when clinically necessary and will be used solely for treatment, documentation, and payment purposes.

I knowingly and willingly authorize the providers at **LifeArts Integrated Health Center, PC** and **LifeArts Medical, LLC** to review my past medical history, current medical conditions, and any other health information relevant to my care. I acknowledge and consent to the use of health information exchange systems that allow for the electronic transmission, receipt, and access of my medical information, which may include treatments, prescriptions, laboratory results, medical and prescription histories, as permitted by law.

I further consent to the use of an electronic clinical documentation system during my visits. This system may record encounters to assist in generating accurate and efficient medical documentation, allowing my provider to focus more fully on my care. I understand that this system complies with HIPAA requirements to protect the privacy and security of my health information.

I acknowledge that no guarantees have been made regarding the outcomes of my care and that all medical treatments carry potential risks and benefits. I understand that multiple healthcare disciplines may be utilized within this facility, and I consent to any treatment or therapy recommended by my provider.

I understand that medical care provided at **LifeArts Medical, LLC** is performed by an **Advanced Practice Registered Nurse (APRN)**. With this knowledge, I knowingly and voluntarily authorize **LifeArts Integrated Health Center, PC** and **LifeArts Medical, LLC** to proceed with my care.

Finally, I acknowledge that I have received, read, and understand the **Patient Office Policies**, therefore I agree to abide by them.

Signature: _____

HIPAA PRIVACY NOTICE & PATIENT RIGHTS CONSENT : Patient Rights Regarding Protected Health Information

Under the Health Insurance Portability and Accountability Act (HIPAA) and applicable Nebraska state law, you have the following rights regarding your Protected Health Information (PHI):

Your Rights

- Right to Access:
  You have the right to inspect and obtain a copy of your medical records and other PHI maintained by this office, with limited exceptions as permitted by law.
- Right to Request Amendment:
  You may request that information in your medical record be amended if you believe it is inaccurate or incomplete. Requests may be denied if the information is accurate, complete, or was not created by this office.
- Right to an Accounting of Disclosures:
  You have the right to request a list of certain disclosures of your PHI made by this office, as permitted by law.
- Right to Request Restrictions:
  You may request restrictions on how your PHI is used or disclosed for treatment, payment, or healthcare operations. We are not required to agree to all requested restrictions, except as required by law.
- Right to Confidential Communications:
  You may request that we communicate with you about your health information in a specific manner or at a specific location (for example, by mail instead of phone), when reasonable.

- Right to Receive a Paper Copy:
  You have the right to receive a paper copy of the Notice of Privacy Practices at any time, even if you have agreed to receive it electronically.
- Right to Be Notified of a Breach:
  You have the right to be notified in the event of a breach of your unsecured PHI, as required by federal and Nebraska law.
- Right to File a Complaint:
  You may file a complaint with this office or with the U.S. Department of Health and Human Services if you believe your privacy rights have been violated. Filing a complaint will not affect your care or benefits.

Our Responsibilities

- We are required by law to maintain the privacy and security of your PHI.
- We must follow the duties and privacy practices described in our Notice of Privacy Practices.
- We will not retaliate against you for exercising your privacy rights.

NOTICE OF PRIVACY PRACTICES

This Notice of Privacy Practices describes how medical information about you may be used and disclosed and how you may access that information. LifeArts Integrated Health Center, PC and LifeArts Medical, LLC are committed to protecting the privacy and confidentiality of your Protected Health Information (PHI) in accordance with HIPAA and applicable Nebraska laws.

As part of providing healthcare services, a medical record is created and maintained documenting the care and services you receive in this office. This Notice explains how your PHI may be used and disclosed for purposes including treatment, payment, and healthcare operations, as well as for other purposes permitted or required by law. It also explains your rights regarding your PHI. Please be aware that independent healthcare providers may practice within the same facility as LifeArts Integrated Health Center, PC and LifeArts Medical, LLC. To promote coordinated and high-quality care, these providers may engage in professional collaboration regarding medical conditions and treatment options. During such discussions, your identity will not be disclosed by name or other identifying information unless you provide specific authorization.

If you consent to identifiable discussion of your case among collaborating providers, please indicate your consent by checking the box next to the provider's name. Any box left unchecked will indicate that you prefer your identity remain confidential during collaborative discussions.

Acknowledgment and Consent

By signing below, I acknowledge that I have received and reviewed the Notice of Privacy Practices. I understand how my Protected Health Information may be used and disclosed, have had the opportunity to ask questions, and confirm that this information has been explained to me in a language I understand.
I understand my rights and responsibilities regarding my Protected Health Information under HIPAA and Nebraska law.

Patient name (Printed): _____
Signature: _____

I authorize LifeArts Integrated Health Center, PC and LifeArts Medical, LLC to release my PHI to the below listed individuals:
Note, if you do not list your family member, we can not disclose any information to them.

____ Dr. Courtney Bradley, DC
____ Erin Smith, FNP-C
____ Other: _____ (example spouse's name, children's name, etc.)
____ Other: _____ (example spouse's name, children's name, etc.)
____ Other: _____ (example spouse's name, children's name, etc.)

Parent/Guardian Signature if Patient is a Minor: _____ Printed Name: _____

FINANCIAL POLICY

Financial Policy & Assignment of Benefits (Nebraska)

Thank you for choosing LifeArts Integrated Health Center, PC and LifeArts Medical, LLC for your healthcare needs. The following Financial Policy outlines our billing, insurance, and payment expectations. Acceptance of these policies is required prior to receiving treatment. Please understand that payment of your financial responsibility is considered part of your care and treatment.

Insurance Responsibility

- As a courtesy, we submit claims to your insurance carrier.
- Contractual write-offs are accepted only when we are contracted with your specific insurance plan.
- It is your responsibility to verify that LifeArts Integrated Health Center, PC, LifeArts Medical, LLC, and Julie Howard, DC, FNP-BC are participating providers with your insurance plan.
- Your insurance policy is a contract between you and your insurance company. We are not a party to that contract.
- You are responsible for all charges not paid by your insurance carrier, including deductibles, copays, coinsurance, and non-covered services.
- Complete, accurate, and current insurance information must be provided prior to services being rendered. Failure to provide this information will result in self-pay status.
- It is your responsibility to understand your insurance benefits, as not all services may be covered.

Assignment of Benefits & Release of Information

I authorize payment of my insurance benefits directly to LifeArts Integrated Health Center, PC, LifeArts Medical, LLC, and Julie Howard, DC, FNP-BC. I understand that I am financially responsible for all non-covered services. I authorize the release of medical information necessary to process insurance claims, coordinate care, and obtain payment from insurance carriers or other healthcare providers, as permitted by HIPAA and Nebraska law.

Copays and Insurance Plans

- When we are a participating provider, all copays, co-insurance, and patient responsibility payments are due at the time of service.

Office Procedures and Laboratory Services

- Not all office services, procedures, or laboratory tests are covered by every insurance plan.
- Any service determined to be non-covered or denied by your insurance carrier is your financial responsibility.

Billing, Statements, and Account Balances

- We do not routinely mail paper statements unless specifically requested.
- Account balances and payment options are available through the patient portal and Healow mobile app.

Collections and Attorney Fees

- Accounts that remain unpaid for 90 days will be referred to our attorney, as permitted by Nebraska law.
- If referred to collections, a 25% collection or attorney fee will be added to the outstanding balance.
- Once an account has been placed in collections, services will be suspended until the balance is paid in full.

Workers' Compensation, Auto Accidents, and Personal Injury Claims

- All workers' compensation, motor vehicle accident, and personal injury visits must be authorized prior to the appointment.
- Complete claim information must be provided, including the responsible party's name, address, phone number, claim number, and date of injury.
- Appointments will be canceled if authorization or claim information is not available.
- If claim information is incomplete or payment is denied, you are responsible for payment within 30 days.

Children and Minors (Under 19 Years of Age)

- Under Nebraska law, the parent or legal guardian is financially responsible for services provided to a minor.
- In cases of divorce or custody arrangements, the adult who presents the minor for care is responsible for payment, regardless of court orders or divorce decrees.
- We do not become involved in disputes related to divorce, custody, or third-party litigation.
- If a minor is seen without a parent or legal guardian present, a valid and current credit card must be maintained on file to cover copays or coinsurance at the time of service.

Accepted Forms of Payment

- Cash, check, Visa, MasterCard, Discover, American Express, HAS cards, debit cards, and money orders are accepted.
- Returned checks will incur a $35 processing fee, and checks will no longer be accepted on the account.

Acknowledgment and Authorization

By signing below, I acknowledge that I have read, understand, and agree to the Financial Policy of LifeArts Integrated Health Center, PC and LifeArts Medical, LLC.

If the patient is a minor, I authorize treatment of the minor without my presence when applicable.

PATIENT SIGNATURE: _____

PATIENT GUARDIAN SIGNATURE: _____ DATE: _____

Printed Patient Name: _____ Date of birth: _____

LifeArts Integrated Health Center, P.C. and
LifeArts Medical, LLC
306 N 7th Street Plattsmouth, NE 68048
402-296-2196 402-296-2197 (fax)
Lifeartsihc.com email: julie.howard@lifeartsihc.com

Patient Consent Form for Credit Card on File & Payment Plan

Patient Name: _____ Account Number (if applicable): _____

1. Credit Card on File Authorization I authorize LifeArts Integrated Health Center, PC / LifeArts Medical, LLC to securely store my credit card information on file for the purpose of processing payments for my healthcare services. I understand and agree that:

- My card will only be charged for services rendered, outstanding balances, copayments, deductibles, coinsurance, and any other unpaid patient responsibilities after insurance adjudication.
- I will receive a receipt via the patient portal and/or email each time my card is charged.
- I can revoke this authorization at any time by providing written notice to the office.
- I will update my current credit card information in a timely manner to avoid payment delays.
- The maximum amount that will ever be charged to my card on file is $500.00.

2. Payment Plan Agreement I agree to a payment plan for any current outstanding balances on my account as of the date of this agreement:

- Payments will be processed automatically using the credit card on file (unless another payment method is arranged in writing).
- Missed or late payments may result in suspension of non-emergency services and/or referral of my account to a collections agency.
- This agreement does not waive my financial responsibility for any services not covered by insurance.

Consent & Signature

I certify that I have read, fully understand, and agree to all the terms outlined above. I authorize LifeArts Integrated Health Center, PC / LifeArts Medical, LLC to charge my credit card in accordance with this agreement and for any applicable services rendered.

Date Agreed and Signed: _____

(the data below will automatically be stored/saved if you present your card to the office for swiping into the system)

Credit card information: Name on card: _____

Number: _____ **Exp. Date:** _____

CVV: _____ **Zip Code:** _____

UNDERSTANDING YOUR INSURANCE

Please initial each line below to verify that you have read and understand the following:

_____Your insurance plan is between you and your insurance company. We are not responsible for, nor do we have knowledge of what services are covered and what are not. If a service is denied due to non-covered service, we will attempt to appeal it once; however, if it is still denied, you are responsible for the charges.

_____Each insurance company usually sells numerous policies often with different benefits. We will try to find information regarding your deductible, co-pay, and/or co-insurance, but we are not always able to do so. Please be proactive and collect this information from your insurance company prior to your office visits and be prepared to pay for your service at the time of the visit.

_____A deductible is an amount determined by your insurance company that you are responsible for paying prior to them covering the payment for services. You may or may not have a deductible.

_____A co-insurance is a percentage of the amount of the covered services that is determined by your insurance company that you are responsible for paying. This often is not applicable until the deductible is met.

_____A co-pay is a specific amount that you may owe for services rendered at the time of the service. This often is not applicable until the deductible is met.

_____Some insurances have a limit on the number of visits you can have in a year, generally this applies to manual therapy treatments. However, even though they allow a certain number of visits, it does not guarantee that they will cover the charges for them as they are generally subject to your deductible, co-insurance or co-pay.

_____If your insurance changes, you are responsible for providing us with updated insurance information as quickly as possible. Delays can cause denials from the new insurance company providing payment for services. If that happens, you will be responsible for the charges.

_____ We do not mail statements for outstanding balances unless we have specifically been asked to mail them. If you have received an explanation of benefits from your insurance that shows a balance that you owe, it is your responsibility to log into your portal to pay that balance. Unpaid balances will receive finance changes. Delinquent accounts will be sent to collections after 90 days of non-payment.

_____ _____

Print Name Date

_____ _____

Signature Printed name of parent/guardian if patient is a minor