Back To Chiropractic CE Seminars

Ethics & Law: Contract Law ~ 2 Hours

Welcome to Back To Chiropractic Online CE exams:

This course counts toward your California Board of Chiropractic Examiners CE.
(also accepted in other states, check our website or with your Chiropractic State Board)

The California Board requires that you complete all of your CE hours BEFORE the end of your Birthday month. We recommend that you send your chiropractic license renewal form and fee in early to avoid any issues.

Exam Process: Please read all instructions before starting!

1. You must register/pay first. If you haven't, please return to: backtochiropractic.net

2. Open a new window or a new internet tab & drag it so it's side-by-side next to this page.

3. On the new window or new tab you just opened, go to: backtochiropractic.net website.

4. Go directly to the Online section. DON'T register again.

5. Click on the Exam for the course you want to take. No passwords needed.

6. Follow the Exam instructions.

7. Upon passing the exam you'll be able to immediately download your certificate, and it'll also be emailed to you. If you don't pass, you can repeat the exam at no charge.

Please retain the certificate for 4 years.
If you get audited and lose your records, I'll have a copy.

I'm always a phone call away... 707.972.0047 or email: marcusstrutzdc@gmail.com

Marcus Strutz, DC
Back To Chiropractic CE Seminars

Disclaimer

Please be advised everything contained within this PowerPoint and/or within this lecture is not intended to be legal advice, counseling or advisement for anything other than informative continuing education purposes. This is not a consultation with an attorney nor an advertisement.

Ethics & Law:

Contract Law

- Damien Fertitta D.C., J.D.

Damien Fertitta D.C., J.D.
Palmer West Graduate 2001
Private Practice
Lincoln Law School Graduate 2018

Objectives

~What is a valid contract?
~Provider contracts.
~Who is bound by a contract?
~What are your liabilities under a provider contract?
~Types of contracts for your office.
~Contracts that benefit the Chiropractor.

Valid Contract

A contract is a promise or set of promises, for the breach of which the law gives a remedy, or the performance of which the law in some way recognizes as a duty.

Statute of limitations

Oral contracts

Contracts that you and the defendant did not write down. (California Code of Civil Procedure section 339.) Most oral contracts will have some sort of writing, e.g., a receipt, a canceled check, etc.

2 years from the date the contract was broken

Contracts in writing

(California Code of Civil Procedure section 337.)

4 years from the date the contract was broken

Types of Contracts

Express contracts are formed by language, oral or written.

Implied-in-fact contracts are formed by the manifestations of assent other than oral or written. This is by conduct.

Express Contracts

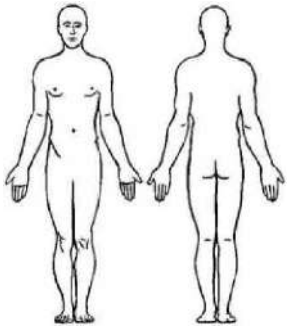
These are the contracts that are formed when a patient walks in your office looking for care.

These are formed when patients sign your office forms.

These are formed when you contract with an employee or a contract with a healthcare provider.

New Patient Form

Full Name:	DOB:	Sex: M / F Marital Status:
Address:	City:	State: Zip:
Telephone: Email:		Occupation:
Describe your current problem and how it began:		**Mark an X on the picture below where you have pain or other symptoms**



Date Problem began:_Is this: Work related_Auto related_N/A_

Current Complaint (how do you feel today): 0 1 2 3 4 5 6 7 8 9 10
No Pain Extreme Pain

How often are your symptoms present? 0-25%_26-50%_51-75%_76-100%_

Can you perform your daily activities? Yes_No_

Have you had spinal Xrays, MRI, CT Scan? No_Yes_Dates taken:_

Please check all the following that apply to you: None apply below_ Height:_Weight:

NO	YES	Condition	NO	YES	Condition
_	_	History of recent infection	_	_	Prostate problems
_	_	Recent fever	_	_	Frequent urination
__		HIV/AIDS	__		Pregnancy # of births:_
_	_	Diabetes	_	_	Abnormal weight: gain_loss_
_	_	Corticosteroid use	_	_	Epilepsy/seisures Visual
_	_	Birth control pills	_	_	disturbances History of
_	_	High blood pressure	_	_	low/mid back pain History of
_	_	Stroke Date:_ _ _			neck pain Arthritis
_	_	Dizziness/fainting	_	_	
_	_	Numbness in groin/buttocks	_	_	History of alcohol use
_	_	Aortic Aneurysm	_	_	History of tobacco use
_	_	Cancer/tumor	_	_	Surgery:_
_	_	Osteoporosis	_	_	Medications:
		Recent trauma			

Family History: Cancer_Diabetis_High blood pressure_Cardiovascular problems/stroke

In accordance with California law, this notice is to inform you, the patient, the risks of undergoing chiropractic care. The procedures that will be performed in the course of your care will consist of chiropractic adjustments using manual and instrumental techniques. The risk of care could include possible fracture of ribs (if you have unusually low bone density). This risk will be evaluated before your care begins. Another risk from a chiropractic adjustment is the risk of stroke. This risk has been determined to be a risk of approximately 1 in 5.85 million. This risk will also be evaluated prior to the onset of your care to see if you have any predisposing factors for a stroke. Furthermore, any medications the patient is taking my have a direct influence on his or her reaction to the adjustment. The medications the patient may be taking may have more adverse health affects and complications. There is also the risk of increased pain during the healing phase of care. As your body begin to be restored to normal health, there may be some periods of time when you will feel symptoms that had previously been gone. Understand that this is normal and indicates healing, as such you may also risk restored health and wellness. The risks of not getting chiropractic adjustment can include disc and spine degeneration, loss of mobility, loss of function of organs or cells that do not have nerve supply restored to them and loss of muscle tone.

My signature below signifies that the risks of chiropractic care have been explained to me verbally and in the above written statement. I understand the risks and give consent for chiropractic treatment.

Signature: Date:

Implied contracts

This is the kind of contract where you enter a hair stylist salon, and you get styled.
This is the type of contract where someone walks into your office and lays on your adjustment table.
These are the contracts that are formed by a person's conduct in accordance with the services that were performed by a the performer.

The creation of a valid contract

The offer must be communicated to an entity. (implied or expressed)

There needs to be acceptance of that offer.

Lastly, there must be consideration given.

What is an offer?

An offer is a communication to an individual, giving that person the power to accept.

Example:

I offer to sell you my practice for $1 million.

Do we have an offer?
Do we have a contract?

Yes, there is an offer.
No, it is not a contract because there has been no acceptance.

I offer to sell you my practice for $1 million, if you pay $10,000 per month for 10 years.

Do we have a contract?

Yes, there is a contract. The promise to sell is the offer. If you accept and pay, there is consideration.

What is consideration?

Consideration is the bargained-for exchange between parties, where there is a legal detriment or a benefit to a party.

Example:

I promise to give my daughter $10,000 if she stops smoking because we have a history of lung cancer in our family. Is this a contract and is there adequate consideration?

Yes, a contract has been formed. The offer to pay the $10,000 is a legal detriment. The detriment to the daughter is she must stop smoking in order to receive the money. The benefit to me is the peace of mind that the smoking may prevent possible cancer. Consideration does not always have to be economic.

The creation of a valid contract

Express written consent is a contract, this informs the patient of the "Risks" and absolves the D.C. of liability for the adjustment. It has offer, acceptance and consideration.

In accordance with California law, this notice is to inform you, the patient, the risks of undergoing chiropractic care. The procedures that will be performed in the course of your care will consist of chiropractic adjustments using manual and instrumental techniques. The risk of care could include possible fracture of ribs (if you have unusually low bone density). This risk will be evaluated before your care begins. Another risk from a chiropractic adjustment is the risk of stroke. This risk has been determined to be a risk of approximately 1 in 5.85 million. This risk will also be evaluated prior to the onset of your care to see if you have any predisposing factors for a stroke. Furthermore, any medications the patient is taking my have a direct influence on his or her reaction to the adjustment.

The medications the patient may be taking may have more adverse health affects and complications. There is also the risk of increased pain during the healing phase of care. As your body begin to be restored to normal health, there may be some periods of time when you will feel symptoms that had previously been gone. Understand that this is normal and indicates healing, as such you may also risk restored health and wellness. The risks of not getting chiropractic adjustment can include disc and spine degeneration, loss of mobility, loss of function of organs or cells that do not have nerve supply restored to them and loss of muscle tone.

My signature below signifies that the risks of chiropractic care have been explained to me verbally and in the above written statement. I understand the risks and give consent for chiropractic treatment.

Signature: _____ Date:_____

Liens

Doctor-Patient liens and

Attorney-Doctor liens are contracts

Liens are very important to have. They record and preserve the right to payment. Without a lien, the patient, and the Doctor will have a dispute about the recovered costs.

PATIENT – ATTORNEY
MEDICAL LIEN AGREEMENT

I, _____do hereby authorize_____to furnish you, _____ my attorney, with prepaid copies of medical records relevant to my injury or accident for which he/she is representing me. I further authorize and direct my attorney to pay directly to _____, such sums of monies as may be due and owing to them, (a) for medical services rendered to me for the injury and/or, (b) for any other services, supplies, or reports, and/or (c) legal medical (i.e. impairment rating reports, attorney-physician conferences, and depositions) and to withhold such sums from any settlement or judgment as may be necessary to adequately protect and pay for my treatment. I hereby grant_____ a lien on my claim against any and all proceeds of any settlement or judgment which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated for/or other related services.

I fully understand that I am directly and fully responsible to the above health care provider for all medical bills submitted by them for services rendered to me and that this agreement is made solely for their additional protection and in consideration of the services provided. I further understand that such payment is not contingent on any insurance company's determination, with the exception of a recognized workers compensation case, as to the appropriateness of services rendered and/or fees charged. Alternate third party payment, if accepted, is done as a courtesy provided by_____ .

By my signature below, I hereby waive and/or relinquish my right to contest and/or otherwise make any legal objections as to the appropriateness of this agreement and that my attorney has advised me of same. I understand that this agreement shall be governed by the laws of the State of _____ .

Patient: _____

Print/Type:_____

Home Address, City, State, Zip_____

ATTORNEY AGREEMENT AND ACCEPTANCE

The undersigned being the attorney for the above client (patient), does hereby agree to observe all the terms of the above agreement to withhold such sums from any settlement or judgment as may be necessary to adequately protect the above listed health care providers and to promptly pay such sums to them upon receipt of payment of any settlement or judgment without demand.

Date:_____

Attorney's Signature _____

Print/Type_____

State Bar No._____

Address_____

*Examples only

Surety

An individual who undertakes an obligation to pay a sum of money or to perform some duty or promise for another in the event that person fails to act. Must be in writing.

For example:

A family comes to your office for some supplements. Joy agrees to pay for her 17 year old daughter's supplements. If the daughter fails to pay for the goods, is there a contract?

Yes, by doing so Joy becomes a surety to the daughter's purchases. You may now seek payment directly from Joy. (In writing)

But remember, there must be consideration for the agreement. Joy's consideration must be given or there is no contract.

Provider's contract

blue of california

ALLIED & ANCILLARY PROVIDER AGREEMENT
[FEE FOR SERVICE]

This ALLIED & ANCILLARY PROVIDER AGREEMENT (this **"Agreement"**) is entered into between California Physicians' Service, dba Blue Shield of California (**"Blue Shield"**) and ABC CHIRO CORP. (**"Provider"**), with reference to the following:

RECITALS

A. Blue Shield is licensed as a prepaid health care service plan under the Knox-Keene Act of 1975 and the regulations promulgated thereunder, each as amended (the **"Knox-Keene Act"**). Blue Shield contracts with individuals, associations, employer groups, and governmental entities to provide or to arrange for the provision of covered health care services to Members (as defined herein) enrolled in health maintenance organization (**"HMO"**), point of service (**"POS"**), exclusive provider organization (**"EPO"**) and preferred provider organization (**"PPO"**) benefit plans.

B. Provider is duly licensed in the State of California, or is an entity comprised of individuals who are duly licensed to practice in the State of California.

C. Blue Shield and Provider desire that Provider be included as a participating provider in its provider networks to provide certain Covered Services (as defined herein) to its Members.

NOW, THEREFORE, the parties hereto agree as follows:

I. DEFINITIONS

The terms set forth in this Agreement shall have the meanings described below, except where the context indicates that such meanings are not intended. In the event of any dispute with regard to the definition of any of the terms, reference to the use of any such disputed term in the Knox-Keene Act shall be controlling:

1.1 **Benefit Program**: is a group or individual health care benefit program offered by Blue Shield pursuant to a Health Services Contract (and riders, if any, thereto).

1.2 **Copayment:** is any copayment, deductible, and/or coinsurance amount for which a Member is financially responsible in connection with the receipt of Covered Services, as specifically described in the Health Services Contract and/or Evidence of Coverage applicable to the Member and in effect as of the date of service. Any other amount which Provider may seek to recover from Members for Covered Services constitutes a surcharge and is prohibited by both this Agreement and the Knox-Keene Act.

The Knox Keene Act set rules for mandatory basic services, financial stability, availability and accessibility of providers, review of providers contracts, administrative organization, and consumer disclosure and grievance requirements.

https://www.chcf.org/wp-content/uploads/2017/12/PDF-MakingSenseManagedCareRegulation.pdf

Knox-Keene Health Care Service Plan Act

of 1975 Including Amendments effective as of January 2014 FOR USE BEGINNING January 2014 STATE OF CALIFORNIA DEPARTMENT OF MANAGED HEALTH CARE 2014 This copy of Knox-Keene Health Care Service Plan Act of 1975, as amended, has been prepared by the California Department of Managed Health Care. It is provided for interested persons' convenience only and should not be relied upon for any other purpose. This copy includes amendments effective January 2014. The Knox-Keene Health Care Service Plan Act of 1975, as amended, (Health and Safety Code Section 1340, et seq.) is found in West's Annotated California Codes and Deering's California Codes.

http://www.capg.org/modules/showdocument.aspx?documentid=1659

395 pages

from time-to-time amended and updated by Blue Shield in accordance with this Agreement, including, without limitation Blue Shield's Medical Policy. Subject to Section 7.4 of this Agreement, Blue Shield from time to time may modify or amend the Provider Manual, provided that Blue Shield shall notify Provider no fewer than forty-five (45) working days prior to the effective date of any change to the Provider Manual and shall make reasonable efforts to ensure that such notices are appropriately and conspicuously labeled.

II. PROVIDER SERVICES

2.1 **Providing Covered Services.** Provider shall provide to Members those Covered Services which Provider is licensed and qualified to provide. Consistent with Section 2240.4 of Title 10 of the California Code of Regulations, Provider's primary consideration shall be the quality of the health care services rendered to Members.

2.2 **Non-Discrimination.** Provider shall provide services to Members in a manner similar to that in which Provider furnishes services to all other Provider patients, and with the same availability afforded to such patients. Provider shall not discriminate against Members on the basis of race, sex, color, religion, national origin, ancestry, age, marital status, physical or mental handicap, health status, disability, need for medical care, utilization of medical or mental health services or supplies, sexual preference or orientation, veteran's status, health insurance coverage, status as a Member, or other unlawful basis including without limitation, the filing by a Member of any complaint, grievance, or legal action against Provider. In providing services to Members, Provider shall comply with all applicable laws including, without limitation, the Americans with Disabilities Act.

2.3 **Authorized Services.** Provider shall, except in the case of Emergency Services, provide Covered Services to Members as authorized in advance by Blue Shield or Blue Shield's delegate as may be required by and in accordance with the utilization management procedures established by Blue Shield and as described in the Provider Manual. In the event Provider concludes that care recommended or authorized through the utilization management program is medically inappropriate for the Member, Provider may access the expedited appeals process as described in the Provider Manual. Provider may also render that care which Provider, in the exercise of good medical judgment, believes is medically appropriate and may appeal any coverage denial by Blue Shield in accordance with the provisions set forth in Article VIII hereof.

2.4 **Provider Referrals.** Except as permitted by the Member's Evidence of Coverage, Provider shall not refer a Blue Shield Member to other health care providers without an advance authorization from Blue Shield or its delegate or otherwise in accordance with the utilization management procedures established by Blue Shield and as described in the Provider Manual. Without limiting the foregoing, if this Agreement applies to Blue Shield commercial HMO, EPO and/or Medicare Advantage Benefit Programs, Provider shall refer commercial HMO, EPO and/or Medicare Advantage Members only to health

II. PROVIDER SERVICES

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§ 2240.4. Contracts with Network Providers.

(a) Insurers shall establish written policies and procedures for recruiting network providers, credentialing network providers, contracting with network providers, and managing their networks.

(b) Effective June 30, 2008, contracts between network providers and insurers or their agents shall: 1) be in writing and be fair and reasonable as to the parties to such contracts; 2) provide that network providers shall not make any additional charges for rendering network services except as provided for in the contract between the insurer and the insured; 3) include all the agreements between the parties pertaining to the rendering of network provider services; 4) recite that the provider's primary consideration shall be the quality of the health care services rendered to covered persons; 5) include provisions ensuring that providers shall not discriminate against any insured in the provision of contracted services on the basis of sex, marital status, sexual orientation, race, color, religion, ancestry, national origin, disability, health status, health insurance coverage, utilization of medical or mental health or substance use disorder services or supplies, or other unlawful basis including without limitation, the filing by such insured of any complaint, grievance, or legal action against a provider.

(c) Insurers shall afford essential community providers equal opportunity to participate in contracts for alternative rates of payment to assure adequacy of number and location of institutional facilities and professional providers in what have been determined to be underserved communities and populations.

(1) An insurer shall not discriminate against a provider on the basis of the provider's qualifying as an essential community provider under state or federal law.

(2) When contracting with an essential community provider, an insurer shall offer contractual terms that are fair and reasonable, and similar to the terms offered to other similarly situated providers.

(3) Nothing in this section shall be construed to require an insurer to contract with an essential community provider if such provider refuses to accept the generally applicable payment rates of the insurer.

(d) An insurer shall notify the Department at least 10 days before the termination of a contract with a provider, provider group, or facility, and in such notice shall demonstrate that its network remains in compliance with the network adequacy requirements of this Article. The notice shall be electronically filed with the Health Policy Approval Bureau through the "California Life & Health" instance of the System for Electronic Rate and Form Filing (SERFF) of the National Association of Insurance Commissioners (NAIC), with the title "2240.4(d) Provider/Facility Termination Notice" in the subject line. In demonstrating compliance, the notice shall describe the other providers or facilities that enable the network to continue to comply with the requirements of this article, notwithstanding the termination of the identified provider(s) or facility/facilities. For providers, an updated report as described in Section 2240.5(c)(1) is an adequate description. For facilities, the other facilities shall be identified, within an updated report as described in Section 2240.5(c)(1).

(e) If a provider has contracted with an insurer to participate in a particular network, the insurer must obtain the provider's written assent before that provider may be included as a participant in other networks of that insurer.

III. COMPENSATION

3.1 **Compensation.** In exchange for the provision of Covered Services to Members Blue Shield shall pay Provider the lesser of (i) the applicable reimbursement rates set forth in Exhibit B hereto, or (ii) Provider's billed charges, in either case, less the Member's applicable Copayment.

3.2 **Payment of Claims.** Blue Shield shall pay all valid and complete claims from Provider for Covered Services upon receipt, in accordance with the timeframes set forth in California law and in accordance with the Blue Shield claims adjudication rules and procedures as set forth in the Provider Manual. Provider shall use best efforts to accept payment for Covered Services and receive related explanations of benefits (**"EOBs"**) via electronic funds transfer (**"EFT"**) and electronic remittance advice (**"ERA"**), respectively. Blue Shield shall give Provider no fewer than sixty (60) days' prior notice of any proposed changes in the Blue Shield Provider Allowances (as described in the Provider Manual) other than those affecting reimbursement for drugs and immunizations, which changes shall not be made more than once during each calendar year, and shall make reasonable efforts to ensure that such notices are appropriately and conspicuously labeled. Changes to the Blue Shield Provider Allowances affecting reimbursement for drugs and immunizations shall be made on the first day of each calendar quarter, as described in the Provider Manual and shall be posted on Blue Shield's website at https://www.blueshieldca.com/provider/. Provider shall bill Blue Shield in accordance with the procedures as set forth in the Provider Manual and as described on Blue Shield's website at https://www.blueshieldca.com/provider/. All claims payments by Blue Shield will be accompanied by an EOB which describes the manner in which the claim was adjudicated and payment was issued. In the event a claim or any portion thereof is denied payment by Blue Shield, Provider will receive an appropriate communication from Blue Shield which describes the basis for the denial and contains all appropriate information as may be required by applicable state and federal law.

3.3 **Timely Submission of Claims.** Provider shall submit complete claims to Blue Shield for Covered Services furnished to Members no later than twelve (12) months from the date such Covered Services were furnished by Provider or, if Blue Shield is not the primary payor under the coordination of benefits rules described in Section 3.6 hereof, the date payment or denial is received by Provider from the primary payor. If Provider fails to submit a claim for Covered Services within the time-frames set forth in this Section, Blue Shield may deny payment of the claim. In such event, Provider waives its right to any remedies and to pursue the claim further, and may not initiate a demand for arbitration or other legal action against Blue Shield or pursue the Member for additional payment; provided, however, that Blue Shield shall, upon submission of a Provider Appeal by Provider, consider good cause for late submission of a claim denied as untimely.

3.4 **Claims Submission.** Provider shall use best efforts to submit claims electronically, following the procedures set forth in the Provider Manual. If, despite best efforts,

Payment of Claims.

Blue Shield shall give Provider no fewer than sixty (60) days' prior notice of any proposed changes in the Blue Shield Provider Allowances

Timely Submission of Claims

…no later than twelve (12) months…Provider waives its right to any *remedies* and to pursue the claim further, and may not initiate a demand for arbitration or other legal action against Blue Shield or pursue the Member for additional payment…Appeal by Provider, consider good cause for late submission of a claim denied as untimely.

Remedies: Your compensation for damages

Provider cannot submit claims electronically, Provider shall submit paper claims using a CMS Form 1500, or any successor form, which includes all information required by the Provider Manual. In either case, payment by Blue Shield will be made only upon receipt of a complete claim submitted by Provider in accordance with this Agreement.

3.5 **Charges to Members.**

(a) In no event, including without limitation nonpayment by Blue Shield, or Blue Shield's insolvency or breach of this Agreement, shall Provider bill, charge, collect a deposit from, impose a surcharge on, seek compensation, remuneration or reimbursement from, or have any recourse against, a Member, or any individual responsible for such Member's care, for Covered Services. Without limiting the foregoing, Provider shall not seek payment from a Member, or any individual responsible for such Member's care, for Covered Services for which payment was denied by Blue Shield because the bill or claim for such Covered Services was not timely or properly submitted. If Blue Shield receives notice of a violation of this Section, it shall have the right to take all appropriate action, including without limitation, the right, following thirty (30) days written notice to Provider, to reimburse the Member for the amount of any payment made and to offset the amount of such payment from any amounts then or thereafter owed by Blue Shield to Provider.

(b) Provider shall not bill or collect from a Member any charges in connection with non-Covered Services, non-authorized services, or services determined not to be Medically Necessary unless Provider has first obtained a written acknowledgment from the Member, or the individual responsible for such Member's care, that such services are either not Covered Services, not authorized, or not Medically Necessary, as the case may be, and that the Member, or the individual responsible for such Member's care, is financially responsible for the cost of such services. Such acknowledgment shall be obtained prior to the time that such services are furnished to the Member and shall satisfy the applicable requirements set forth in the Provider Manual. Notwithstanding the foregoing, if, due to specific circumstances, Provider is not reasonably able to obtain such acknowledgment prior to the time the services are rendered, Provider shall be permitted to seek payment from the Member for such non-Covered Services.

(c) In the event of Blue Shield's insolvency or other cessation of operations, Provider shall continue to provide Covered Services to Members through the period for which such Members' premiums have been paid, or, with respect to Members enrolled in Blue Shield's Medicare Advantage Benefit Program, the duration of the contract period for which the Centers for Medicare and Medicaid Services (**"CMS"**) payments have been made, and, with respect to any Member who is confined in an inpatient facility on the date of insolvency or other cessation of operations, until the Member's discharge.

Charges to Members.

In no event, including without limitation nonpayment by Blue Shield, or Blue Shield's insolvency or breach of this Agreement, shall Provider bill, charge, collect a deposit from, impose a surcharge on, seek compensation, remuneration or reimbursement from, or have any recourse against, a Member, or any individual responsible for such Member's care, for Covered Services. Without limiting the foregoing, Provider shall not seek payment from a Member, or any individual responsible for such Member's care…

…unless Provider has first obtained a written acknowledgment from the member…In the event of Blue Shield's insolvency or other cessation of operations, Provider shall continue to provide Covered Services to Members through the period for which such Members' premiums have been paid…

Association (as defined in Section 9.13) in the State of California, Provider shall submit to Blue Shield for processing all claims for medical services (including, without limitation, Provider Services) furnished by Provider and reimbursable through the BlueCard Program.

(b) Nothing in Section 3.10(a) shall be construed to require Provider to submit to Blue Shield for processing claims for Provider Services furnished to a Member enrolled in a benefit plan having an exclusive arrangement with another licensee of the Association in the State of California, it being expressly understood that claims for Provider Services furnished to a Member enrolled in a benefit plan having an exclusive arrangement with a particular licensee of the Association in the State of California should be sent to and processed by such licensee.

IV. REPRESENTATIONS AND WARRANTIES OF PROVIDER

4.1 **Licenses & Insurance.** At all times during the term of this Agreement, Provider shall, and if Provider is comprised of a group of licensed providers, each such licensed provider shall:

(a) be licensed under the laws of the State of California to provide the services described in Exhibit A, and such license shall be free of any restrictions or limitations;

(b) be in compliance with all applicable local, state and federal laws relating to the provision of services hereunder, and furnish such services in accordance with all applicable licensing requirements and all local standards of professional ethics and practice;

(c) maintain in effect such policies of general and professional liability insurance and other insurance as shall be necessary and appropriate to insure him/her/it and his/her/its employees against any claims or claims for damages arising by reason of or indirectly in connection with the provision of Covered Services pursuant to this Agreement; provided that such insurance shall have limits of not less than One Million Dollars ($1,000,000) per each occurrence and not less than Three Million Dollars ($3,000,000) in the aggregate per calendar year; and

(d) provide evidence to Blue Shield of compliance with the forgoing requirements set forth in this Section 4.1.

4.2 **Authority to Bind Group.** If Provider is comprised of a group of licensed providers, then the signatory hereto warrants that he/she has the authority to bind each of the providers listed in Attachment 1 to Exhibit A hereto, as from time to time modified in accordance with Section 4.4(a). Moreover, Provider agrees that the provisions of this Agreement bind all officers, members or employees of Provider who are similarly licensed, including all

Authority to Bind Group

If Provider is comprised of a group of licensed providers, then the signatory hereto warrants that he/she has the authority to bind each of the providers…

MAINTENANCE AND INSPECTION OF RECORDS

Such records described herein shall be maintained at least six (6) years from the date of service, and, if this Agreement is applicable to Blue Shield Medicare Benefit Programs, ten (10) years from the end of the final contract period between Blue Shield and CMS or the completion of any audit of Blue Shield or its contractors by DHHS…

(California Department of Managed Health Care)

when CMS or DMHC requests such longer record retention and Provider is notified of such request by Blue Shield), and in no event for a shorter period than as may be required by the Knox-Keene Act. All books, documents, and records of Provider shall be maintained in accordance with the general standards applicable to such book, document or record keeping and shall be maintained during any audit or investigation by Government Officials.

5.2 **Site Evaluations/Onsite Audits.** Provider shall permit Government Officials and Blue Shield to conduct periodic site evaluations, inspections, and onsite audits of their facilities and records. Blue Shield shall provide Provider five (5) business days' advance notice (or fewer if mutually agreed upon by the parties) of any proposed site and record evaluation, inspection, or onsite audit by Blue Shield. If Government Officials or Blue Shield find any deficiencies in such facilities or records, Provider shall have thirty (30) days to substantially correct such deficiencies which are identified by such Government Official or Blue Shield.

5.3 **Accreditation Surveys.** Provider shall cooperate in the manner described in Sections 5.1 and 5.2 hereof with respect to surveys and site evaluations relating to accreditation of Blue Shield by NCQA or any other accrediting organization. Further, Provider agrees to implement any changes reasonably required as a result of all such surveys. Provider shall fully cooperate with Blue Shield with regard to the Healthcare Effectiveness Data and Information Set (HEDIS) measurements and HEDIS audits, guideline development, preventive services utilization, disease/risk management, clinical service monitoring and quality improvement studies and initiatives.

5.4 **Performance/Compliance Monitoring.** Provider shall cooperate with Blue Shield in the performance of any monitoring, studies, evaluations, analyses or surveys required by Government Officials, accrediting organizations, or the Association (as defined in 9.13) of Provider's performance of services hereunder. Provider shall receive reasonable advance notice of any proposed monitoring, studies, evaluations, analyses or surveys by Blue Shield. Nothing in this Agreement shall prohibit Blue Shield from using, releasing, and/or publishing Provider performance data.

5.5 **Quality Assurance Programs.** Provider agrees to participate in any and all quality improvement and utilization management programs implemented by Blue Shield as more fully described in the Provider Manual. Moreover, Provider agrees to participate in Blue Shield's provider credentialing and recredentialing programs. If Provider concludes that care recommended or authorized through the utilization management program is medically inappropriate for the Member, Provider may access the expedited appeal process as described in the Provider Manual. Provider may also furnish that care which Provider, in the exercise of good medical judgment, believes is medically appropriate and may appeal any coverage denial by Blue Shield in accordance with the provisions of Article VIII hereof.

Site Evaluations/Onsite Audits

Blue Shield shall provide Provider five (5) business days' advance notice…Provider shall have thirty (30) days to substantially correct such deficiencies which are identified by such Government Official or Blue Shield.

Accreditation Surveys

Provider shall cooperate in the manner described in Sections 5.1 and 5.2 hereof with respect to surveys and site evaluations relating to accreditation of Blue Shield by NCQA or any other accrediting organization. Further, Provider agrees to implement any changes reasonably required as a result of all such surveys.

Performance/Compliance Monitoring

Nothing in this Agreement shall prohibit Blue Shield from using, releasing, and/or publishing Provider performance data.

TERM & TERMINATION

…either party may terminate this Agreement without cause by giving the other party at least one hundred twenty (120) days' prior written notice of termination.

Employment Agreement

THIS AGREEMENT (employment contract) made as of the _____day of _____, 20__ , between[name of employer] a corporation incorporated under the laws California, and having its principal place of business at _____(the "Employer");and [name of employee], of the City of _____.(the "Employee").

WHEREAS, the Employer desires to obtain the benefit of the services of the Employee, and the Employee desires to render such services on the terms and conditions set forth.

IN CONSIDERATION of the promises and other good and valuable consideration (the sufficiency and receipt of which are hereby acknowledged) the parties agree as follows:

1. Employment

The Employee agrees that he will at all times faithfully, industriously, and to the best of his skill, ability, experience and talents, perform all of the duties required of his position. In carrying out these duties and responsibilities, the Employee shall comply with all Employer policies, procedures, rules and regulations, both written and oral, as are announced by the Employer from time to time. It is also understood and agreed to by the Employee that his assignment, duties and responsibilities and reporting arrangements may be changed by the Employer in its sole discretion without causing termination of this agreement.

2. Position Title

As a _____, the Employee is required to perform the following duties and undertake the following responsibilities in a professional manner.

(a) -

(b) -

(c) -

(d) -

(e) Other duties as may arise from time to time and as may be assigned to the employee.

3. Compensation

(a) As full compensation for all services provided the employee shall be paid at the rate of ____. Such payments shall be subject to such normal statutory deductions by the Employer.

(b) (may wish to include bonus calculations or omit in order to exercise discretion).

(c) The salary mentioned in paragraph (l)(a) shall be review on an annual basis.

(d) All reasonable expenses arising out of employment shall be reimbursed assuming same have been authorized prior to being incurred and with the provision of appropriate receipts.

4. Vacation

The Employee shall be entitled to vacations in the amount of ____ weeks per annum.

5. Benefits

The Employer shall at its expense provide the Employee with the Health Plan that is currently in place or as may be in place from time to time.

6. Probation Period

It is understood and agreed that the first ninety (90) days of employment shall constitute a probationary period during which period the Employer may, in its absolute discretion, terminate the Employee's employment, for any reason without notice or cause.

7. Performance Reviews

The Employee will be provided with a written performance appraisal at least once per year and said appraisal will be reviewed at which time all aspects of the assessment can be fully discussed.

8. Termination

(a) The Employee may at any time terminate this agreement and his employment by giving not less than two (2) weeks written notice to the Employer.

(b) The Employer may terminate this Agreement and the Employee's employment at any time, without notice or payment in lieu of notice, for sufficient cause.

(c) The employee agrees to return any property of _____at the time of termination.

9. Non-Competition

(1) It is further acknowledged and agreed that following termination of the employee's employment with _____ for any reason the employee shall not hire or attempt to hire any current employees of _____.

(2) It is further acknowledged and agreed that following termination of the employee's employment with _____ for any reason the employee shall not solicit business from current clients or clients who have retained_____ in the 6-month period immediately preceding the employee's termination.

10. Forum selection

This agreement shall be governed by the laws of California.

11. Independent Legal Advice

The Employee acknowledges that the Employer has provided the Employee with a reasonable opportunity to obtain independent legal advice with respect to this agreement, and that either:

(a) The Employee has had such independent legal advice prior to executing this agreement, or;

(b) The Employee has willingly chosen not to obtain such advice and to execute this agreement without having obtained such advice.

12. Entire Agreement

This agreement contains the entire agreement between the parties, superseding in all respects any and all prior oral or written agreements or understandings pertaining to the employment of the Employee by the Employer and shall be amended or modified only by written instrument signed by both of the parties hereto.

13. Severability

The parties agree that in the event any article or part thereof of this agreement is held to be unenforceable or invalid then said article or part shall be struck and all remaining provision shall remain in full force and effect.

IN WITNESS WHEREOF the Employer has caused this agreement to be executed by its duly authorized officers and the Employee has set his hand as of the date first above written. SIGNED, SEALED AND DELIVERED in the presence of:

_____

[Name of employee]

_____

[Signature of Employee]

_____

[Name of Employer Rep]

_____

[Signature of Employer Rep]

[Title]

Contracting to buy or sell your chiropractic office

Corporations vs Sole practitioners

Objectives

~What is goodwill?
~Negotiating the contract.
~Avoid ambiguities.
~What are your liabilities as a sole practitioner, and as a Corporation?
~Avoiding adverse consequences.

Buying or selling goodwill?

Defining Goodwill

Regs. Sec. 1.197-2(b)(1) defines goodwill as "the value of a trade or business attributable to the expectancy of continued customer patronage," and that "[t]his expectancy may be due to the name or reputation of a trade or business or any other factor."

Two types of goodwill

1. Personal, professional, or practice goodwill is subsequently referred to as personal goodwill.
2. Business enterprise, practice, or institutional goodwill is subsequently referred to as business goodwill. (intangible assets)

The businesses goodwill represents the hidden intrinsic value of the business. This is the "*bling*" factor to a well run and well respected practice.

Is goodwill 50% of annual collections?

Is goodwill 30% of gross profit?

Is goodwill 75% of the overhead?

The goodwill of your practice is a combination of many things.

Example A

500k in practice revenue per year. This office has 65% overhead. 325k costs per year. +175K

Example B

400K in practice revenue per year. This office has 35% overhead. 140k costs per year. +260K

As you can, see it is more than just how much revenue a practice brings in. While there is no exact formula for this calculation, it will always depend on multiple variables.
Collections, overhead, growth rate of the practice, and growth rate demographically.

Now you have found your target price

Negotiations between the buyer and seller can be difficult. Sometimes the owner may be reluctant to negotiate away their sweat equity. The price, terms and conditions are sensitive points for both parties. Unless there is a cash sale, the seller remains at risk. What if the buyer defaults? What if patients don't mesh with the new D.C.? What is the buyer's return on investment? This represents a small fraction of possible complications that arise.

The key to success is for the buyer and seller to be on the same playing field.

Does the D.C. have personality traits common to yours?

Is their technique similar to your own?

What was, or is, the target practice's vision?

Key players

A broker experienced in sales of this nature.
An experienced CPA.
An attorney to draw up a contract.
These are just a few options for you to consider.

Numbers

Expected return on practice/investment.

Profit and loss statements.

Past Bank records.

New patient numbers and retention.

Own, lease or rent the space?

What is the overhead?

Finally

Make sure there are clear intentions of both the buyer and the seller. Address the buyer's and seller's needs. Have an open dialogue and avoid ambiguities that may bring up complications.

Sole practitioners, Professional Corporations

Sole practitioners (Sole proprietor):

A sole proprietor is someone who owns an unincorporated business by himself or herself.

https://www.irs.gov/businesses/small-businesses-self-employed/sole-proprietorships

Advantages

This is the simplest business form. The ease of setup and cost are nominal. May operate under the name of its owner, or under a fictitious business name. The taxation is quite simple.

Disadvantages

A sole proprietor remains personally liable for all the business's debts. If a sole proprietor business runs into financial trouble, creditors can bring lawsuits against the business owner. The owner will have to pay the business debts with his or her own money. The owner signs a contract in his or her own name.

Professional Corporations

Professional corporations or professional service corporations (abbreviated PC or PSC) statutes make special provisions, regulating the use of the corporate form by licensed professionals such as attorneys, architects, chiropractors, engineers, public accountants and physicians.

PC or PSC can elect to be "S" or "C" Corp.

Advantages

The ability to shield and limit the personal liability of the professional corporation's shareholders from ordinary business debts and obligations.

Shield the corporation from negligent acts of employees within the scope of employment.

Tax advantages to qualified small business owners.

Disadvantages

Professional corporation does not insulate a professional for personal liability for her own negligence or malpractice.

Flat 21% corporate tax rate.

Minimum costs of $800 in state fees per year.

Example

Assume you are the only shareholder of your corporation. The corporation has a profit of $100,000. A "C" corp., would pay a corp. tax of 21% ($21,000), leaving you to receive a dividend* of $79,000. If your tax rate is 20% you will be left with $62,410

*60% of the dividend is reasonable

Example

Having an "S" corp., there would be no corp. tax to pay. The $100,000 profit would pass through to you as a dividend. If your tax rate is 20% you will be left with $80,000

Depending on the source, there are around +/-13,000 active chiropractic licenses in the state of California. There are +/-11,720 sole practitioners. Of those, approximately 1,280 are professional corporations.

A national chiropractic association is threatening legal action against UnitedHealthcare over a recent policy change that pulled coverage for an alternative therapy for patients with severe migraines.

In a letter to UnitedHealthcare CEO Dan Schumacher, American Chiropractic Association (ACA) President N. Ray Tuck Jr. said he was "astounded" to find out the insurer would no longer cover chiropractic spinal manipulative therapy (SMT) for patients with migraines and severe headaches.

The letter, which was also signed by more than two dozen state chiropractic associations, said United Healthcare no longer covers the treatment, labeling it "unproven and/or not medically necessary." The groups pointed to eight studies over eight years that support the use of spinal manipulation, including a March study that showed the treatment could reduce the frequency of headaches by 30%

https://www.fiercehealthcare.com/payer/american-chiropractic-association-unitedhealthcare-spinal-manipulation-coverage

Thanks for taking CE Seminars with Back To Chiropractic.
I hope you enjoyed the course. Please feel free to provide feedback.

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Free Materials: Notes & Forms hundreds of files ~ posters, newsletters & more
Services & Listings People helping people for free

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