First & Last Name of Provider: ____

Soteria Healthcare Network

Chiropractic Network Participation Checklist & Application

PRO TIPS TO HELP YOU!

BEFORE COMPLETING THIS APPLICATION, SOTERIA HEALTHCARE HAS THE FOLLOWING REQUIRMENTS:

1. You must have at least 2 years of professional work experience;
2. On-Site X-ray Machine; and
3. Be a Medicare participating provider.

PLEASE READ BEFORE YOU START:

- Our Application is similar to CAQH Data Summary "order" of appearance.
- Only one provider per Application.
- If you move offices/locations in GA, don't worry, your network participation moves with you.
- Do you work out of multiple locations? Your application/participation in Soteria may apply at those offices as well.
- Once completed, please save as a PDF and email your Application (with attachments) to credentialing@soteriahealthcare.com; or mail a copy of this Application (with attachments - see Checklist below). Please keep a copy for your records.
- If answers are not complete and/or accurate, this may delay your participation and entry into the network.
- Please sign, date and complete the information to the best of your knowledge/ability on the following pages.
- Upon final approval and completion of all necessary materials/attachments, you can be effective in typically, 15-30 days. It can take longer if attachments/or information is incomplete. Upon final approval and completed credentialing application, Soteria will send you a signed Agreement w/ your effective date.
- **If something does not apply, please write N/A**.

CHECKLIST of REQUIRED ATTACHMENTS

√ Attach a current copy of your Professional Liability Malpractice Insurance (i.e. "Declaration Page") w/ expiration date;
  - *Please note, the date of the application you listed (above; top left) should be within the active dates on your Declaration Page.*

√ Attach a copy/photo of your current "Business Liability Coverage" Declaration Page with expiration date.
  - *Please note, the date on this application should be within the date on your declaration page.*

√ Attach a copy of your current "Georgia Chiropractic License."

√ (IF APPLICABLE) Attach a copy of any current certifications, diplomas or specialty training certificates.

If you or your staff have any questions/comments, please call 770-455-8190 ext 135.

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By completing this document, in part or in whole, (ie signature pages, attestation pages, application, Schedule(s), W-9, contract, etc.), you understand, authorize and agree that your electronic signature is legally binding to these documents and authorize Soteria Healthcare Network, Inc., to use this signature and Application to proceed and complete the entire credentialing process.*

PERSONAL DETAILS | SECTION 1

Today's Date: _______/_______/__________ Degree ______________________________ Total Years In Practice: ________

First Name: ____________________ Middle Initial: ___ Last Name (Incl. Suffix, Jr., Sr., III) ______________________________

Have you used other names? (Check Box) ___Yes ___No Maiden or Other Names Used: ____________________________

Home Address: ____

Address (Line 2) ______________________ City: _________________________________ State: _____ Zip: ______________

Email Address: ____ Home Phone: ___________________________

Social Security Number: _________________________ Date of Birth ________________ Gender ____________________

Marital Status (Optional; Check Box) ____ MARRIED ____ SINGLE _____ OTHER

Spouse First Name (optional) ______________________ Spouse Last Name (optional) ____________________________

Are you eligible to work in the United States? (Check Box) __ Yes ___No Place of Birth (City/State/Country) _______________

Citizen of U.S.A.? (Check Box) ___Yes ____No Visa Type: ___________ Status/Exp: __________

(If not US Citizen, please provide type and status of Visa and enclose a copy of your birth certificate and/or Visa documentation)

SOTERIA HEALTHCARE NETWORK® **First & Last Name of Provider:** ____

PROFESSIONAL DETAILS | SECTION 2

Georgia Chiropractic License # ___________________________ Expiration (mm/yy) _________ Issue Date (mm/yy) _________

Has your license ever been relinquished or revoked? (Check Box) ____Yes _____No If Yes, please list reason(s) online below.

____

Are you a Participating Medicare Provider? (Check Box) ____Yes _____No Medicare # (Indiv): ___________________

Are you a Participating Medicaid Provider? (Check Box) ____Yes _____No Medicaid # (Indiv): ___________________

National Provider Identifier (NPI; Type 1 Individual) ________________________________

Do you have an Educational Commission for Foreign Medical Graduates (ECFMG) Number? ___ Yes or ___ Does Not Apply.

Other State Health Care Licenses, Registrations & Certificates ___ **Does Not Apply**

Please include all ever held. If more room is needed please list on an attached explanation form.

Type _________________ Active __ Yes __ No Number _______________ State/Country ________ Exp. Date (mm/yy)________

Year Obtained: ___________ Year Relinquished ___________ Reason _______________________________

Type _________________ Active __ Yes __ No Number _______________ State/Country ________ Exp. Date (mm/yy)________

Year Obtained: ___________ Year Relinquished ___________ Reason _______________________________

PROFESSIONAL EDUCATION | SECTION 3

Chiropractic School Name: ____ Country: ___________

City/State of School Attended: ____

Degree Earned: _________________________ Start Date: __________________ Grad Date/End: ______/______/______

Did you complete the program? (Check Box) ____Yes _____No. (If no, please describe circumstances below)

____

Undergraduate Education | SECTION 3 A

Undergraduate School Name: ______________________________________ Country: _______________

City/State of School Attended: ____

Degree Earned: __________________ Course of Study or Major: ________________________ Grad Date/End (mm/yy) _________

TRAINING DETAILS (If Yes, please describe on "Explanation Page"; p. 11) | SECTION 4

Internship: (Check Box) _____Yes ________ Does Not Apply

Residency: (Check Box) _____Yes ________ Does Not Apply

Fellowship: (Check Box) _____Yes ________ Does Not Apply

Have you completed cultural competency training? (Check Box) _____Yes ________ Does Not Apply

Other Training: (Check Box) For example, preceptorship, procedural certificate course, etc. _____Yes ________ Does Not Apply

Faculty Positions: (Check Box) _____Yes ________ Does Not Apply

BOARD CERTIFICATION DETAILS | SECTION 5

PLEASE CAREFULLY READ BEFORE YOU COMPLETE THIS SECTION.

- **Have you obtained an NBCE Certification (Completion of Parts I, II, III and IV)** ___ **Yes** ___ **No**
- **Do you have an active license, in good standing, by the Georgia Board of Chiropractic Examiners?** ___ **Yes** ___ **No**
- **Are you Board Certified in any Recognized ACA Board Certifications?**
  ____**Yes** ____ **No (Please list below)** ___ **Does Not Apply.**
  (Examples: DABCA; DABCI; DACNB; DACBOH, DABCP)

Please note, only a small percentage of the chiropractors licensed in the U.S. have earned the right to list board certification in a chiropractic specialty on their curricula vitae. Board certification demonstrates that a chiropractic physician has completed postgraduate chiropractic medical education, which signifies exceptional skills in specialty areas such as orthopedics, radiology and sports medicine. Chiropractors who have attained diplomate status have earned the right to use specialty credentials. These credentials indicate an advanced practice status earned through postgraduate clinical training and passing of specialty board examinations.

Name of Issuing Board ____**Specialty** __________________

Date Cert. (mm/yy) _________ Date Recert. (mm/yy) _______ Date Recert. (mm/yy) _______ Exp. Date (if any; mm/yy) ___________

If you are not currently certified, have you applied for a certification examination? ____Yes _____No

If you have not applied for a certification examination, do you intend to apply for a certification examination? ____Yes ____No

If you have been accepted, when do you intend to take the certification exam? (mm/yy) ____________

If you do not intend to apply for a certification or re-certification examination, please explain. ______________________

____

SOTERIA HEALTHCARE NETWORK®

First & Last Name of Provider: ______________________________

PRACTICE & TECHNIQUE/METHOD | SECTION 6

Techniques Used: Exclusive (95%+) ______________________ Preferred (less than 95%)______________________

Other Techniques Used (please describe) ______________________________

Do you utilize (Check all that apply) *If checked, please include protocols for use and list equipment used, include type, make, etc.*

___ EMG ____________________
___ Thermography ____________________
___ Electro-Diagnostic ____________________
___ Ultrasound ____________________
___ Manual/Intersegmental Traction
___Diathermy
___ Faradic ____________________
___ Galvanic ____________________
___ High-Volt ____________________
___ Interferential ____________________
___ Other (Please list or describe) ____________________

Please explain protocols for determining the need for x-ray(s) ______________________________

Please list the most common and number of modalities utilized as part of a treatment plan:

____

Please list the average frequency/duration of chiropractic treatment for a patient with a soft tissue injury and continued subjective complaint(s) with minimal objective findings. __________ times per week for ________ weeks. Additional comment(s), if req'd.:

____

PRACTICE LOCATION(S) DETAILS | SECTION 7

Do you currently practice at this location (listed below)? ____ Yes _____ No Start Date (mm/yy) ____________________

Primary Practice Name: ______________________________

Practice Full Address: ______________________________

City ____________________ State ________ County____________________ Zip ____________________

Mailing Address (if different from above) ______________________________

Office Tel. ________________ Office Fax: ________________ Office Email: ______________________

Appointment Scheduling Web Site: ______________________________

Can general correspondence be sent to this address? (Check Box) ____Yes _____No (If no, please provide address and fax on the line below)

Practice Setting (Check Box) _____GROUP _____ SOLO

If you are not currently in practice, please describe your intentions regarding beginning and/or reinstating your practice:

____

Does this office qualify as a minority owned business enterprise? (Check box) _____Yes _____ No

Do you have an organization NPI #-Type 2) ____ Yes ____ No NPI (Type 2) # ______________________

Medicaid Group Number: ____________________ Medicare Group Number: ______________________

Phone Number: ____________________ Fax #____________________ Back Office Tel. ________________

Do you have 24 hour /7 day a week phone coverage available? _____ Yes _____ No

If yes, indicate type of coverage arrangements. ______________________________

⇒ At this location, I provide service(s) to patients within _______ hours OR, _______ days for emergency/urgent needs.

⇒ At this location, I provide service(s) to patients within _______ hours OR, _______ days for routine/maintenance care.

⇒ **AM HOURS:** _______ Mon _______ Tues _______ Wed _______ Thurs _______ Fri _______ Sat _______ Sun

⇒ **PM HOURS:** _______ Mon _______ Tues _______ Wed _______ Thurs _______ Fri _______ Sat _______ Sun

⇒ Do You or your Staff Speak Any Languages Spoken Other Than English, including ASL (Describe) ____________________

⇒ Do you take history, physical and x-rays at the initial visit for all patients? ___ YES or NO ___

⇒ Do you routinely prepare a written Plan of Treatment during your initial history and physical? ___ YES or NO ___

⇒ On-Site X-Ray ___ YES or NO Make: ________________ Model: ________________ Size Unit: __________ KV: _______ MA: ______

⇒ Year Manufactured: ____________ Table Bucky: ____Wall Bucky: ____ Date of Last State X-Ray Certification: ________________

Tax Information | SECTION 7 A

Practice Name as it appears on W-9 ______________________________

Tax ID: ________________ Provider Directory Classification Type: ___ Acupuncture ___ Chiropractor ___ Massage Therapy

Based on your contracted agreement, do you wish to be listed in the Directory under your primary specialty? ___ YES or NO ___

Patients | SECTION 7 B

Do you accept new patients at this location? ____ Yes ____ No

Do you accept existing patients with change of payor at this location? ____ Yes ____ No

Do you accept all new patients at this location? ____ Yes ____ No

Do you accept new Medicare patients at this location? ____ Yes ____ No

Do you accept new Medicaid patients at this location? ____ Yes ____ No

Do you accept new patients from chiropractor/physician referral **only**? (i.e. referring letter) ____ Yes ____ No

SOTERIA HEALTHCARE NETWORK **First & Last Name of Provider:** ____________________

Colleagues At This Location Include | SECTION 7 C

Do you have any Partners/Associates at this location? Note, if Group Practice, please list the names (first and last) of all of the other providers also practicing at this location.

____

Do you have any massage therapists, nutritionist, dieticians, acupuncturists at this location? ____ Yes ____ No

(If yes, please include contact info below)

Type of Provider: _____ Massage Therapist _____ Acupuncturist _____ Nutritionist/Dietician

First name: ____________ Last Name: ____________ Middle Initial: ________

Phone Number: ____________ Ext. ________ Fax Number: ____________

Email: ____________ Is Office Manager Credentialing Contact: ___Yes ___ No

Credentialing Contact (If different from Office Manager) Full Name ____________ Tel. ____________

Billing Contact Information | SECTION 7 D

Name of Office Manager/Administrative Contact: ____________

Office Manager Tel. ____________ Office Manager Email ____________

Payment and Remittance SECTION 7 E

Billing Representative Name ____________ Tel. ____________ Ext. ________

Other Limitations: ____________

Accessibility | SECTION 7 F

Does this office provide handicapped accessibility? (Check box) ____ Yes _____ No

Do you provide handicap accessibility for each of the following areas?

Exterior Building ____Yes _____No
Interior Building ____Yes _____No
Wheelchair access to exam room ____Yes _____No
Exam table/scale/chair ____Yes _____No
Parking ____Yes _____No
Restroom ____Yes _____No

Does this location have other services for the disabled?

American Sign Language (ASL) ____Yes ____No
Mental/Physical Impairment Services ____Yes ____No
Other disability services ____Yes ____No

Is this office accessible by public transportation? ____Yes ____No
If Yes, indicate type of transportation: ____________

- Does this office meet all state and local fire, safety and sanitation requirements? ____Yes ____No
- Do you accept Workers Compensation Patients? ____Yes ____No
- Are staff trained in identification and care of patients with work-related illness/injury and provide care/services with an active return to work philosophy? ____Yes ____No
- Modified or alternative duty is actively evaluated for each workers' Compensation claimant? ____Yes ____No
- Office will accommodate urgent walk-ins (or non-urgent appointments within 48-hours) to treat injured or ill workers and facilitate their return to work, if possible, Staff are available and willing to provide compensation representatives information regarding a claimant's care. ____Yes ____No

Services | SECTION 7 G

Does this location provide any of the following services:

Laboratory ____Yes ____No
Radiology ____Yes ____No
Allergy Injections/Skin Testing ____Yes ____No
X-Ray On Site ____Yes ____No
EKG Testing ____Yes ____No
Pulmonary Function Testing ____Yes ____No
Tympanometry/Audiometry Screening ____Yes ____No
Physical Therapy Services ____Yes ____No

Additional Office Procedures Not Listed Above, Please Describe ____________

Is anesthesia administered in your office? ____Yes ____No

If yes, anesthesia administered by: (First and Last Name) ____________

What class/category of anesthesia is used? ____________

What emergency equipment is available? ____________

SOTERIA HEALTHCARE NETWORK

First & Last Name of Provider: ____

Certifications (Do you or someone in your office have the following additional certifications?) | SECTION 7 H

BLS – Basic Life Support: ___ Yes ___ No _____________ Expiration
ACLS – Advanced Cardiac Life Support: ___ Yes ___ No _____________ Expiration
ALSO – Advanced Life Support in OB: ___ Yes ___ No _____________ Expiration
PALS – Pediatric Advanced Life Support (Classification) ___ Yes ___ No _____________ Expiration
ATLS – Advanced Trauma Life Support (Certified) ___ Yes ___ No _____________ Expiration
CPR – Cardio-Pulmonary Resuscitation Classification: ___ Yes ___ No _____________ Expiration
Other (please specify): _____________________________________ - _____________ Expiration

PROFESSIONAL LIABILITY INSURANCE | SECTION 8

Current/Active Professional Liability Insurance

Policy Number: __________________________________ Effective Date (mm/yy) ________ Exp Date (mm/yy) ___________

Insurance Carrier/Provider of Professional Liability Coverage: ____

Type of Coverage: ___ Claims Made ___Occurrence Telephone: ________________________________

Address of Carrier: ____

Per Claim Limit of Liability ___________ Aggregate Amount ______________ Retroactive Date (if applicable; mm/yy) ___________

If you have changed your coverage within the last ten years, did you purchase tail and/or nose (prior occurrence/acts) coverage?
____ YES or NO ____ (If yes, please explain) ____

NOTE: IF YOU ARE COVERED BY A MEDICAL PROFESSIONAL LIABILITY INSURANCE PROGRAM THAT IS A CLAIMS MADE POLICY, YOU ARE REQUIRED TO SHOW EVIDENCE OF PURCHASE OF CURRENT REPORTING ENDORSEMENT COVERAGE (TAIL COVERAGE) OR PRIOR OCCURRENCE/ACTS COVERAGE TO COVER PREVIOUS YEARS OF PRACTICE.

PREVIOUS PROFESSIONAL LIABILITY INSURANCE

Please list all previous professional liability carriers within the past 10-years.

Policy Number: _______________________________ Effective Date (mm/yy) ________ Exp Date (mm/yy) ___________

Insurance Carrier/Provider of Professional Liability Coverage: ____

Type of Coverage: ___ Claims Made ___Occurrence Telephone: ____________________________________

Address of Carrier: ____

Per Claim Limit of Liability ___________ Aggregate Amount ______________ Retroactive Date (if applicable) ______________

PREVIOUS PROFESSIONAL LIABILITY INSURANCE

Policy Number: _______________________________ Effective Date (mm/yy) ________ Exp Date (mm/yy) ___________

Insurance Carrier/Provider of Professional Liability Coverage: ____

Type of Coverage: ___ Claims Made ___Occurrence Telephone: ____________________________________

Address of Carrier: ____

Per Claim Limit of Liability ___________ Aggregate Amount ______________ Retroactive Date (if applicable) ______________

PEER REFERENCES | SECTION 9

Minimum of 3 required; Please list 3 references from licensed professional peers who have personal knowledge of are directly familiar with your professional competence, conduct and work. No relatives. At least one reference must be a practitioner in your same professional discipline.

NAME OF REFERENCE #1 ________________________________ **Specialty** ________________________________
Dates of Association (mm/yy – mm/yy) __________________________ Telephone: ______________________________
Email: ____ City/State: ________________________________

NAME OF REFERENCE #2 ________________________________ **Specialty** ________________________________
Dates of Association (mm/yy – mm/yy) __________________________ Telephone: ______________________________
Email: ____ City/State: ________________________________

NAME OF REFERENCE #3: ________________________________ **Specialty** ________________________________
Dates of Association (mm/yy – mm/yy) __________________________ Telephone: ______________________________
Email: ____ City/State: ________________________________

SOTERIA HEALTHCARE NETWORK® **First & Last Name of Provider:** ____

PROFESSIONAL PRACTICE / WORK HISTORY DETAILS | SECTION 10

PLEASE LIST IN REVERSE CHRONOLOGICAL ORDER ALL WORK AND PROFESSIONAL AND PRACTICE HISTORY.

Current Employment Information Record | Section 10 A

Practice/Employer Name: ________________________________ Start Date: ____________ End Date: ____________
Complete Address: ____
City: ________________________________ State ______ Zip ______________________ Phone: ____________________
Name of Contact Person ____ Is this your current employer? ___ Yes ___ No

Previous Employment Information Record #1

Practice/Employer Name: ________________________________ Start Date: ____________ End Date: ____________
Complete Address: ____
City: ________________________________ State ______ Zip ______________________ Phone: ____________________
Name of Contact Person ____ Is this your current employer? ___ Yes ___ No

Previous Employment Information Record #2

Practice/Employer Name: ________________________________ Start Date: ____________ End Date: ____________
Complete Address: ____
City: ________________________________ State ______ Zip ______________________ Phone: ____________________
Name of Contact Person ____ Is this your current employer? ___ Yes ___ No

Previous Employment Information Record #3

Practice/Employer Name: ________________________________ Start Date: ____________ End Date: ____________
Complete Address: ____
City: ________________________________ State ______ Zip ______________________ Phone: ____________________
Name of Contact Person ____ Is this your current employer? ___ Yes ___ No

Employment Gaps | SECTION 10 B

Please explain/describe any employment gaps over 30 days in your work history (I.e. Military; Births; Surgeries; Medical Leave; Etc)

GAP #1
Start Date of Gap (Mo./Yr) ________________ End Date of Gap (Mo./Yr) ________________
Explanation: ____

GAP #2
Start Date of Gap (Mo./Yr) ________________ End Date of Gap (Mo./Yr) ________________
Explanation: ____

GAP #3
Start Date of Gap (Mo./Yr) ________________ End Date of Gap (Mo./Yr) ________________
Explanation: ____

SOTERIA HEALTHCARE NETWORK

First & Last Name of Provider: ______________________________

DISCLOSURE INFORMATION (GA) | SECTION 11

Malpractice Claims History / Professional Malpractice Claims History | SECTION 11 A

1. Have there ever been any professional liability (i.e. malpractice) claims, suits, judgements, settlements, or arbitration proceedings involving yKB IF YES, please fill out Schedule B on page 14. ___ **YES** ___ **NO**

2. Are any professional liability (i.e. malpractice) claims, suits, judgements, settlements or arbitration proceedings involving you currently pending? IF YES, please write on Explanation Form, page 11. ___ **YES** ___ **NO**

3. Are you aware of any formal demand for payment or similar claim submitted to your insurer that did not result in a lawsuit or other proceeding alleging professional liability? *IF YES, please write on* Explanation Form, page 11. ___ **YES** ___ **NO**

Board Certification | SECTION 11 B   Does Not Apply ____

1. Have you ever had board certification revoked, limited, suspended, involuntarily relinquished, subject to stipulated or probationary conditions, received a letter of reprimand from a specialty board, or is any such action currently pending or under review? *IF YES, please write on Explanation Form, page 11.* ___ **YES** ___ **NO**

2. Have you ever voluntarily relinquished a board certification, including any voluntary non-renewal of a time limited board certification? *IF YES, please write on Explanation Form, page 11.* ___ **YES** ___ **NO**

Professional Insurance History | SECTION 11 C

1. Has your professional liability insurance coverage ever been terminated or not renewed by action of the insurance company? IF YES, please write on Explanation Form, page 11. ___ **YES** ___ **NO**

2. Have you ever been denied professional liability insurance coverage? *IF YES, please write on* Explanation Form, page 11. ___ **YES** ___ **NO**

3. Has your present professional liability insurance carrier excluded any specific procedures from your insurance coverage? IF YES, please write on Explanation Form, page 11. ___ **YES** ___ **NO**

Health Status | SECTION 11 D

1. Do you currently have any physical or mental conditions(s) that may affect your ability to practice or exercise the clinical privileges or responsibilities typically associated with the specialty and position for which you are submitting this Application? (Note: Physical or mental conditions(s) include, but are not limited to, current alcohol or drug dependency, current participation in aftercare programs for alcohol or drug dependency, medical limitation of activity, workload, etc., and prescribed medications that may affect your clinical judgement or motor skills.) IF YES, please explain on Explanation Form, page 11. ___ **YES** ___ **NO**

2. Are you able to perform all the essential functions of the position for which you are applying, safely and according to accepted standards of performance, with or without reasonable accommodation? If reasonable accommodation is required, please specify such on an attached explanation form. ___ **YES** ___ **NO**

Attestation Questions | SECTION 12

IF YES, please write on Explanation Form, page 11.

1. To your knowledge, have you ever been the subject of an investigation or adverse action (or is an investigation or adverse action currently pending) by a hospital or other healthcare facility (e.g. surgical center, nursing home, renal dialysis facility, etc.)? ___ **YES** ___ **NO**

2. To your knowledge have you ever been the subject of an investigation or adverse action (or is an investigation or adverse action currently pending by an education facility or program (medical school, residency, internship, etc.)? ___ **YES** ___ **NO**

3. To your knowledge, have you ever been the subject of an investigation or adverse action (or is an investigation or adverse action currently pending) by a professional organization or society? ___ **YES** ___ **NO**

SOTERIA HEALTHCARE NETWORK® **First & Last Name of Provider:** ______________________________

4. To your knowledge, have you ever been the subject of an investigation or adverse action (or is an investigation or adverse action currently pending) by a professional licensing body (in any jurisdiction for any profession)? ___ YES ___ NO
5. To your knowledge, have you ever been the subject of an investigation or adverse action (or is an investigation or adverse action currently pending by a private, federal, or state agency regarding your participation in a third party payment program (Medicare, Medicaid, HMO, PPO, PHO, PSHCC, network, system, managed care organization, etc.? ___ YES ___ NO
6. To your knowledge, have you ever been the subject of an investigation or adverse action (or is an investigation or adverse action currently pending) by a state or federal agency (DEA, etc.) regarding your prescription of controlled substances? ___ YES ___ NO
7. To your knowledge, have you ever been the subject of any reports(s) to a state or federal data bank or state licensing or disciplining entity? ___ YES ___ NO
8. Has your application for clinical privileges or medical staff membership or change in staff category at any hospital or healthcare facility ever been denied in whole or in part or is any such action pending? ___ YES ___ NO
9. Have you ever resigned from a hospital or other healthcare facility medical staff to avoid disciplinary action, investigation or while under investigation or is such an investigation pending? ___ YES ___ NO
10. Have you ever been suspended, fined, disciplined, sanctioned, or otherwise restricted or excluded from participating in any federal or state health insurance program (for example, Medicare or Medicaid)? ___ YES ___ NO
11. Have you ever been suspended, fined, disciplined, sanctioned, or otherwise restricted or excluded from participating in any private health insurance program? ___ YES ___ NO
12. Has any professional review organization under contract with Medicare or Medicaid ever made an adverse quality determination concerning your treatment rendered to any patient? ___ YES ___ NO
13. Have you ever been convicted of or entered a plea for any criminal offense (excluding parking tickets)? ___ YES ___ NO
14. Are any criminal charges currently pending against you? ___ YES ___ NO
15. Have you ever been arrested for or charged with a crime involving children? ___ YES ___ NO
16. Have you ever been arrested for or charged with a sexual offense? ___ YES ___ NO
17. Have you ever been arrested for or charged with a crime involving moral turpitude? ___ YES ___ NO
18. Are you currently using illegal drugs or legal drugs in an illegal manner? ___ YES ___ NO
19. Have you ever been convicted of or charged with a felony? ___ YES ___ NO
20. Have you ever, while under investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship residency, preceptorship, or other clinical educational program? ___ YES ___ NO

First & Last Name of Provider: ______________________________________

Attestation Statement and Signature | SECTION 13

By signing this Application, I certify, agree, understand and acknowledge the following:

1. The information in this entire Application, including all subparts and attachments, is complete, current, correct, and not misleading.
2. Any misstatements or omissions (whether intentional or unintentional) on this Application may constitute cause for denial of my Application or summary dismissal or termination of my membership or Practitioner Participation Agreement.
3. A photocopy of this Application, including this Attestation the authorization and release of information form and any or all attachments has the same force and effect as the original.
4. I have reviewed the information in this Application on the most recent date indicated below and it continues to be true and complete.
5. While this Application is being processed, I agree to update the information originally provided in this Application should there be any change in the information.
6. No action will be taken on this Application until it is complete and all outstanding questions with respect to the Application have been resolved.
7. This Attestation Statement and Application must be signed, dated and no more than 180-days prior to the credentialing decision date.

SIGNATURE ______________________________ DATE (mm/dd/yy) ____________________

PRINTED NAME ____

By completing this document, in part or in whole, (ie signature pages, attestation pages, application, Schedule(s), W-9, contract, etc.), you understand, authorize and agree that your electronic signature is legally binding to these documents and authorize Soteria Healthcare Network, Inc., to use this signature and Application to proceed and complete the entire credentialing process.

SOTERIA HEALTHCARE NETWORK®

First & Last Name of Provider: ______________________________

By completing this document, in part or in whole, (ie signature pages, attestation pages, application, Schedule(s), W-9, contract, etc.), you understand, authorize and agree that your electronic signature is legally binding to these documents and authorize Soteria Healthcare Network, Inc., to use this signature and Application to proceed and complete the entire credentialing process.

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

▶ Go to *www.irs.gov/FormW9* for instructions and the latest information.

Give Form to the requester. Do not send to the IRS.

Print or type.
See **Specific Instructions** on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶ ________

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) ________

Exemption from FATCA reporting code (if any) ________

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I **Taxpayer Identification Number (TIN)**

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

☐☐☐ – ☐☐ – ☐☐☐☐

or

Employer identification number

☐☐ – ☐☐☐☐☐☐☐

Part II **Certification**

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here **Signature of U.S. person ▶** **Date ▶**

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*

Cat. No. 10231X Form **W-9** (Rev. 10-2018)

NOTE: THIS FORM IS ALSO AVAILALE ONLINE AT: https://www.irs.gov/pub/irs-pdf/fw9.pdf

First & Last Name of Provider: ______________________________

EXPLANATION FORM | SECTION 14

Please make as many copies of this page as needed to fully respond to each question. For each response/explanation, please add the corresponding page from the application AND SECTION NUMBER/SECTION LETTER (i.e. Section 11C, page 7).

SECTION		PAGE #
11 C	Example/explain.	P. 7

Schedule A

GEORGIA UNIFORM HEALTHCARE PRACTITIONER CREDENTIALING APPLICATION FORM

AUTHORIZATION AND RELEASE OF INFORMATION FORM

Modified Releases Will Not Be Accepted

By submitting this Application, including all subparts and attachments, I acknowledge, understand, consent and agree to the following:

1. As an applicant for medical staff membership at the designated hospital(s) and/or participation status with the health care related organization(s) [*e.g. hospital, medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), physician hospital organization (PHO), managed care organization, network, medical society, professional association, medical school faculty position, or other healthcare delivery entity or system (hereinafter referred to as a "Healthcare Entity")*] indicated on this Application, I have the burden of producing adequate information for proper evaluation of this Application.

2. I also understand that I have the continuing responsibility to resolve any questions, concerns or doubts regarding any and all information in this Application. If I fail to produce this information, then I understand that the Healthcare Entity will not be required to evaluate or act upon this Application. I also agree to provide updated information as may be required or requested by the Healthcare Entity or its authorized representatives or designated agents.

3. The Healthcare Entity and its authorized representatives or designated agents will investigate the information in this Application. I consent and agree to such investigation and to the disciplinary reporting and information exchange activities of the Healthcare Entity as a part of the verification and credentialing process.

4. I specifically authorize the Healthcare Entity and its authorized representatives and designated agents to obtain and act upon information regarding my competence, qualifications, education, training, professional and clinical ability, character, conduct, ethics, judgment, mental and physical health status, emotional stability, utilization practices, professional licensure or certification, and any other matter related to my qualifications or matters addressed in this Application (my "Qualifications").

5. I authorize all individuals, institutions, schools, programs, entities, facilities, hospitals, societies, associations, companies, agencies, licensing authorities, boards, plans, organizations, Healthcare Entities or others with which I have been associated as well as all professional liability insurers with which I have had or currently have professional liability insurance, who may have information bearing on my Qualifications to consult with the Healthcare Entity and its authorized representatives and designated agents and to report, release, exchange and share information and documents with the Healthcare Entity, for the purpose of evaluating this Application and my Qualifications.

6. I consent to and authorize the inspection of records and documents (including medical records and peer review information) that may be material to an evaluation of this Application and my Qualifications and my ability to carry out the clinical privileges/services/participation I have requested. I authorize each and every individual and organization with custody of such records and documents to permit such inspection and copying as may be necessary for the evaluation of this Application. I also agree to appear for interviews, if required or requested by the Healthcare Entity, in regard to this Application.

7. I further consent to and authorize the release by the Healthcare Entity to other Healthcare Entities and interested persons on request of information the Healthcare Entity may have concerning me (including but not limited to peer review information which is provided to another Healthcare Entity for peer review purposes), as long as in each instance such release of information is done in good faith and without malice. I hereby release from all liability the Healthcare Entity and its authorized representatives or designated agents from any claim for damages of whatever nature for any release of information made in good faith by the Healthcare Entity or its representatives or agents.

Schedule A--continued

GEORGIA UNIFORM HEALTHCARE PRACTITIONER CREDENTIALING APPLICATION FORM

AUTHORIZATION AND RELEASE OF INFORMATION FORM

Modified Releases Will Not Be Accepted

By submitting this Application, including all subparts and attachments, I acknowledge, understand, consent and agree to the following:

8. I release from any liability, to the fullest extent permitted by law, all persons and entities (individuals and organizations) for their acts performed in a reasonable manner in conjunction with investigating and evaluating my Application and Qualifications, and I waive all legal claims of whatever nature against the Healthcare Entity and its representatives and designated agents acting in good faith and without malice in connection with the investigation of this Application and my Qualifications.

9. For hospital or medical staff membership/clinical privileges, I acknowledge that I have been informed of, and hereby agree to abide by, the medical staff bylaws, rules, regulations and policies. I agree to conduct my practice in accordance with applicable laws and ethical principles of my profession. I also agree to provide for continuous care for my patients.

10. Any investigations, actions or recommendations of any committee or the governing body of the Healthcare Entity with respect to the evaluation of this Application and any periodic reappraisals or evaluations will be undertaken as a medical review and/or peer review committee and in fulfillment of the Healthcare Entity's obligations under Georgia law to conduct a review of professional practices in the facility, and are therefore entitled to any protections provided by law.

11. I have read and understand this Authorization and Release of Information Form. A photocopy of this Authorization and Release of Information Form shall be as effective as the original and shall constitute my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this Application. This Authorization and Release shall apply in connection with the evaluation and processing of this Application as well as in connection with any periodic reappraisals and evaluations undertaken. I agree to execute such additional releases as may be required from time to time in connection with such periodic reappraisals and evaluations.

Signature:	
Printed Name:	**Date:**

I grant permission for the release of the credentials information contained in this Application to the following Healthcare Entity(ies):

Soteria Healthcare Network, Inc.
4080 McGinnis Ferry Road
Building 800, Suite 801
Alpharetta, GA 30005
Tel. 770-455-8190

By completing this document, in part or in whole, (ie signature pages, attestation pages, application, Schedule(s), W-9, contract, etc.), you understand, authorize and agree that your electronic signature is legally binding to these documents and authorize Soteria Healthcare Network, Inc., to use this signature and Application to proceed and complete the entire credentialing process.

SOTERIA HEALTHCARE NETWORK® **First & Last Name of Provider:** ______________________________

By completing this document, in part or in whole, (ie signature pages, attestation pages, application, Schedule(s), W-9, contract, etc.), you understand, authorize and agree that your electronic signature is legally binding to these documents and authorize Soteria Healthcare Network, Inc., to use this signature and Application to proceed and complete the entire credentialing process.

Schedule B

Claim ___ of ___

GEORGIA UNIFORM HEALTHCARE PRACTITIONER CREDENTIALING APPLICATION FORM

PROFESSIONAL LIABILITY CLAIMS INFORMATION FORM

The following information is necessary to complete the credentialing verification process and will be kept confidential. Please print or type answers to the following for any malpractice claims reported to your malpractice insurance carrier, opened, closed, settled or paid. For initial credentialing, please complete a separate form for each claim; for recredentialing, complete forms only for new/changed status claims since your last recredentialing. One case per sheet *(please photocopy if additional sheets are needed).*

PROVIDER'S NAME: *(Required even if N/A)*		**Does Not Apply** ☐ *Note: Signature Required even if checked.*

Name of Patient Involved	Age	Month and Year of Occurrence *(Event precipitating claim)*	Month and Year of Lawsuit	Insurance Carrier at Time
		/	/	

What is/was your status?	List other defendants:
☐ Primary Defendant ☐ Co-Defendant ☐ Other, please explain:	

What was the patient's outcome?

How were you alleged to have caused harm or injury to this patient?

Please provide specifics in reference to the adverse event:

What is/was your role in this event?

CURRENT STATUS			
☐ Still pending (as of) Date: /		Who is handling the defense of the case?	
☐ Trial date set - awaiting trial		Trial Date: /	
☐ Dismissed		Date of Dismissal: /	
☐ Defense Verdict		Date of Defense Verdict: /	
☐ Settled out of court	Date: /	Total Amount of Settlement: $	Amount Paid by You: $
☐ Judgment	Date: /	Total Amount of Judgment: $	Amount Paid by You: $

This Professional Liability Claims Information Form is required on all claims/lawsuits that are reported by your malpractice insurance carrier and/or the National Practitioner Data Bank. Clinical details are required for all suits, regardless of status or settlement amount.

I certify that the information contained in this form is correct and complete (even if N/A) to the best of my knowledge.

Signature: (Required)		**Date:**	

By completing this document, in part or in whole, (ie signature pages, attestation pages, application, Schedule(s), W-9, contract, etc.), you understand, authorize and agree that your electronic signature is legally binding to these documents and authorize Soteria Healthcare Network, Inc., to use this signature and Application to proceed and complete the entire credentialing process.

Schedule C

GEORGIA UNIFORM HEALTHCARE PRACTITIONER CREDENTIALING APPLICATION FORM

REGULATION ACKNOWLEDGEMENT

NOTICE TO PHYSICIANS

Medicare and Tri-Care payment to hospitals is based in part on each patient's principal and secondary diagnosis and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record.

Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

By my signature below, I acknowledge receipt of this notice.

Signature:	
Printed Name:	**Date:**

NEW MEMBER ATTESTATION & SIGNATURE PAGE | SECTION 15

I certify that all of the information submitted by me in this document is accurate, true and complete to the best of my knowledge and belief.

I understand that any misstatement in or omissions from this document constitutes cause for denial or termination of participation in Soteria Healthcare Network, Inc. (herein Soteria)

I understand that I have the right to correct information used in the initial credentialing or recredentialing process, including information submitted by myself or another party. This right does not extend to information prohibited from release by statute, such as the NPDB report or peer review documents. If Soteria has received conflicting information from a third party, I will be notified via the Credentialing Department/Supervisor at Soteria.

I understand that this application does not entitle me to participation in the network of any health plan using the application. I agree that any health plan using this application, their representatives, and any individuals or entitles providing information to such health plan in good faith shall not be liable for any act or omission related to the evaluation or verification contained in this application. I further agree to notify the health plan with which I participate, and which use this application about any changes to the information provided in this application by the next business day. Information requested in this application that is not publicly available will be treated as confidential by the health plan using it.

I authorize Soteria, or its agents, or designated representatives, to contact and consult with administrators, administrative staff, licensing organizations and/or professional peers at intuitions and health care or other organizations with which I am or have been associated, and with past and present insurance carriers, who may have information relating to my professional and ethical qualifications, competence, character and personality.

I consent to the inspection by Soteria, or its designated representative(s) for Soteria beneficiaries of all records regarding beneficiaries, including institutions and health care organizations with which I am or have been associated which may contain information related to my professional and ethical qualifications, competence, character and personality.

I release from liability all individuals, corporations and organizations which provide information to Soteria in good faith, including medical and otherwise privileged or confidential information.

I release Soteria, it's chiropractic administrators, management agents, directors, and staff from liability for acts performed in good faith in connection with the evaluation and investigation of information and materials I have authorized them to request and inspect.

I release Soteria, its administrators, staff directors and management agents from liability for disclosing information obtained in the course of their efforts to evaluate and/or investigate my qualifications and from liability for responding in good faith to inquiries from persons or entities to whom I may submit applications for employment and privileges in the future. I agree that photocopies, electronic transmissions and/or electronic signatures of this signed authorization will be acceptable as an original signature.

I understand that Soteria will rely upon the information given on this document during the evaluation of my credentials to determine compliance with network credentialing standards.

Provider Full Name (REQUIRED) ______________________________

State License #: ______________________ **Today's Date (REQUIRED; mm/dd/yy)** ______________

Provider Signature (REQUIRED) ______________________________

By completing this document, in part or in whole, (ie signature pages, attestation pages, application, Schedule(s), W-9, contract, etc.), you understand, authorize and agree that your electronic signature is legally binding to these documents and authorize Soteria Healthcare Network, Inc., to use this signature and Application to proceed and complete the entire credentialing process.

First & Last Name of Provider: ______________________________________

Standard Chiropractor Agreement and Signature Page

THIS SECTION/BOX FOR SOTERIA OFFICE USE ONLY (PLEASE DO NOT FILL OUT)
A copy of this finalized and "signed" by both part(ies) Agreement will be sent to you in your final acceptance package.

This Agreement is made by and between Soteria Healthcare Network, Inc., (herein "Soteria"), a Georgia for-profit corporation and ____ (herein "Provider") a health care provider holding a license to provide health care services in the State of ______________________________. The effective date of this Agreement shall be the date all required information and enrollment fees are received by Soteria that is____________(Mo.)/___________(Day)/____20__________(Year) ("Effective Date"). IN WITNESS WHEREOF, Provider has executed this Agreement, effective as of the date and year indicated above. "SOTERIA".

"SOTERIA" SIGNATURE
Full Name of Soteria Managing Director ______________________________________
Soteria Managing Director Signature ______________________________ **Today's Date (mm/dd/yy)** ________________

PLEASE COMPLETE THE BOX BELOW

Provider Full Name (REQUIRED) ______________________________________
Provider Signature (REQUIRED) ______________________________ **Today's Date (REQUIRED)** ___/___/___

Georgia License Number ____________________ **NPI Number** ________________ **TIN** ________________

Telephone ______________________________ **Fax** ________________________

Clinic/Organization Name and Address ______________________________________

____

____

By completing this document, in part or in whole, (ie signature pages, attestation pages, application, Schedule(s), W-9, contract, etc.), you understand, authorize and agree that your electronic signature is legally binding to these documents and authorize Soteria Healthcare Network, Inc., to use this signature and Application to proceed and complete the entire credentialing process.

WHEREAS, Soteria contracts with certain doctors of CHIROPRACTIC, medical physicians, diagnostic and rehabilitation centers and other health care professionals to provide access, at a reasonable cost, to comprehensive, integrated health care services to individuals and persons covered by health care plans, workers' compensation insurance plans, auto liability plans or programs which are offered or administered by persons with which Soteria contracts; and

WHEREAS, Provider desires to participate in Soteria and become a member of the panel of participating CHIROPRACTORs, medical physicians, and other health care providers providing health care services to the beneficiaries of the health care, workers' compensation or auto liability plans offered or administered by Soteria and clients under contract with Soteria.
NOW THEREFORE, in consideration of the promises and mutual covenants herein contained, the parties hereby agree as follows:

1. DEFINITIONS. For purposes of this Agreement the following terms shall be defined as follows:

1A. "Beneficiary" means an employee, dependent or individual covered under or entitled to benefits from or through a Payor or a participant in the "Value Plan".

1B. "Health Care Services" means the performance of services for which the Health Care Provider is duly licensed to perform in accordance with existing state law.

1C. "Soteria Provider" means a duly licensed health care services provider who has entered into a Provider Agreement with Soteria to provide health care services to Beneficiaries and whose Provider Agreement is then current.
1D. "Non-Soteria Provider" means health care providers not participating with or contracted by Soteria.

1E. "Medical Necessity or Medically Necessary" means services or supplies which, under the provisions of this Agreement are: (1) provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease; and not for experimental, investigational, or cosmetic purposes; (2) necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms; (3) within generally accepted standards of care in the community; and (4) not solely for the convenience of the insured, the insured's family, or the Provider.

1F. "Payor" means a workers' compensation, liability, group health, self-insured employer, union trust, self-insured workers' compensation trust or fund, employer, preferred provider organization, health maintenance organization or other managed care plan, or a party acting on such an entity's behalf which has entered into a contract with Soteria with respect to the provision of health care services by Soteria Providers to Beneficiaries.

1G. "Payor Contracts" means an agreement between Soteria and a Payor pursuant to which Soteria agrees to arrange for the delivery of Soteria Provider's professional services within the Provider's training and experience to Beneficiaries.

1H. "Program" means the network of Soteria Providers made available to the Beneficiaries of Payors by Soteria and the utilization review, quality assurance, marketing, claims repricing, credentialing, discount plans, consulting and other services provided or offered by Soteria in connection with the network.

1I. "Risk-Sharing Agreement" means an arrangement to provide provider services in which (1) the arrangement does not restrict the ability, or facilitate the refusal, of Providers participating in the arrangement to deal with Payors individually or through another arrangement, and (2) all Providers participating in the arrangement share substantial financial risk from their participation in the arrangement through: (a) the provision of provider services to Payors at a capitated rate; (b) the provision of provider services for a percentage of premium or revenue from Payors; (c) the use of significant financial incentives (e.g., substantial withholds) for its Participating Providers, as a group, to achieve specified cost-containment goals; or (d) the provision of a complex or extended course of treatment that requires the substantial coordination of care by physicians in different specialties offering a complementary mix of services, for a fixed, predetermined payment, where the costs of that course of treatment for any individual patient can vary greatly due to the individual patient's condition, the choice, complexity, or length of treatment, or other factors.

1J. "Value Plan" means an arrangement to provide health care services to Beneficiaries at a discounted fee. Beneficiaries are responsible for payment and no insurance is

involved.

2. PROVIDER SERVICES AND RESPONSIBILITIES.

2A. Provider Commitment. Provider shall cooperate fully with Soteria to provide appropriate and cost-competitive care to Beneficiaries through the application of efficient and aggressive utilization management programs as provided in this Agreement.

2B. Professional Services. Provider shall, within the scope of Provider's licensure, training and experience, and subject to Provider's standard operating policies and procedures, provide all Medically Necessary Health Care Services to Beneficiaries which are in accordance with the respective contract between Soteria and Payor. Provider shall provide Health Care Services to Beneficiaries in the same manner as those services are provided to all other of Provider's patients, utilizing resources and materials according to good standards of CHIROPRACTIC care. Provider shall not discriminate against any Beneficiary, nor deny limit nor condition any coverage of benefits to a Beneficiary in the provision of health care services. Provider is responsible for maintaining an appropriate doctor/professional-patient relationship with individual Beneficiaries and none of the provisions contained in this agreement has or is intended to have an effect of infringing upon Provider's relationships with individual patients.

2C. Access to Care. Provider agrees to provide Health Care Services in a manner to afford timely access to Beneficiaries for care. Accordingly, Provider shall maintain office hours which are adequate to service the health care needs of Beneficiaries. Provider further agrees to treat Beneficiaries during Provider's regular business hours, subject to prior appointments, except that for emergency or other extraordinary situations, Provider shall treat Beneficiaries in a manner required by sound health care practices. Provider agrees that Beneficiaries requiring: (1) emergency care shall be handled and referred as deemed necessary for the good of the Beneficiary and in accordance with sound health care practices; (2) urgent care shall be seen the same day or referred to another Soteria Provider, if available, or appropriate medical or health care specialist; (3) non- urgent care shall be seen within forty-eight (48) hours or referred to another Soteria Provider, if available, or appropriate health care Provider.

2D. Licenses and Insurance. Provider has and shall throughout the term of this Agreement maintain in good standing all licenses and permits required by state law for Providers profession. Provider has and shall throughout the term of this Agreement maintain professional liability (malpractice) Insurance with minimum coverage amounts of $1 million/$3 million or as determined by Soteria Healthcare to be an appropriate level for the Health Care Provider's specialty. Provider shall also maintain adequate property liability Insurance with minimum coverage amounts as established from time to time by the Soteria Board of Directors. Failure to maintain said licenses and liability Insurance shall be grounds for immediate termination of this Agreement. If Provider obtains a claims-made Insurance policy to fulfill his/her obligations under this Section, Provider agrees to (1) maintain coverage with the same company during the term of this Agreement and for at least ten years following termination of this Agreement, or (2) purchase extended reporting requirement coverage ("tail coverage") upon termination or expiration of any claims-made policy. Evidence of licenses and Insurance shall be provided to Soteria upon request. Provider shall notify Soteria of any change in the information regarding such insurances including a minimum of thirty (30) days prior notice of any change in insurance status or policy information.

2E. Adverse Action/Change in Status. Provider shall notify Soteria immediately if any action or sanctions are taken in respect to Provider's licenses, certifications or permits, if any legal actions are initiated, or if governmental or similar action is taken against Provider. Provider has accurately submitted information to Soteria in order to become a Soteria Provider and shall notify Soteria of any change in the information submitted including a minimum of thirty (30) days notice of any change in his/her/its principal place of business.

2F. Contracting Activities. Soteria shall review all proposals and may, in its sole discretion, execute a Payor Contract regarding such proposal on behalf of any or all of its Soteria Providers. Upon execution of any Payor contract, Soteria shall inform Soteria Provider in writing of the name of the Payor and shall provide a Term Summary Sheet of the Payor Contract to Provider. A copy of the Payor Contract can be made available to Provider upon written request. Provider shall be obligated by the terms of the Payor Contract to provide Medically Necessary services to Beneficiaries as provided in the Payor Contracts and this Agreement. When Provider receives Term Summary Sheet listing the salient terms of the Payor Contract. Provider may decline to accept the Payor Contract offered by providing Soteria with written notice of Provider's decision to decline the Payor Contract within five (5) working days after receipt of the Term Summary Sheet. Provider will not discuss or disseminate to Soteria and Soteria Providers information regarding fees charged by Provider for professional services except as necessary pursuant to terms of this Agreement. Nothing in this Agreement shall: (1) constitute an agreement or commitment by Provider to charge a particular fee or level of fees for any service rendered by Provider or; (2) require that Provider change Provider's standard procedures and practices with respect to professional fees. Professional fees charged for non-covered services and charges to all patients not subject to such Payor Contracts or Value Plan are not affected under this Agreement.

2G. Direct Payment of Benefits. Soteria shall be authorized to negotiate contracts with Payors deemed to provide significant potential benefit to Soteria Providers that include a requirement that Soteria Providers accept direct payment from Payors or Soteria for all Medically Necessary services provided to Beneficiaries. These Agreements shall permit Soteria Providers to bill and collect from Beneficiaries: (1) applicable co-payments and deductibles and, (2) charges for non-Medically Necessary services for which the Beneficiary has agreed in writing in advance of the services being rendered to assume financial responsibility. For other than the conditions set forth in this provision, Provider hereby agrees that in no event, including but not limited to Soteria or Payor insolvency or Contract breach by Soteria or Payor Contract, shall Provider bill, balance-bill, charge, seek payment or initiate legal action against for the purpose of obtaining payment from any Beneficiary or persons or entities other than the Contracted Payor or, if a Risk-Sharing agreement, Soteria, for services provided pursuant to this Agreement. If payment is made to Soteria for Medically Necessary services but payment is issued in Provider's name, Provider hereby authorizes Soteria to accept and negotiate that payment subject to Soteria' remittance to Provider of the fees owed to the Provider for those Medically Necessary services. Provider agrees to return any and all payments and/or overpayments made in error to Provider by Soteria and/or a Payor Contract. Further, Provider hereby authorizes Soteria to collect amounts due from Provider for overpayments, payments made in error, or fees due to Soteria or a contracted Payor, including but not limited to, enrollment and/or credentialing fees, from any and all remittances which may be due to Provider from Soteria.

2H. Referrals and Consultations. Provider agrees to refer Beneficiaries only to Soteria Providers for consultations and Health Care Services, unless referral to a non-Soteria Provider is Medically Necessary or, as appropriate, specifically requested by the Beneficiary and approved in advance and subject to the provisions of the Payor Contract.

2I. Terms of Payor Contracts. Provider understands there will be a separate Term Summary Sheet, substantially in the Form attached hereto as Exhibit A, for each Payor Contract and the Value Plan. The Term Summary Sheet shall state the name of the Payor, the effective date, and any other information deemed pertinent by Soteria. Such Term Summary Sheets will automatically become part of and incorporated into this Agreement. Soteria shall provide Providers with notice of each Payor Contract within a reasonable timeframe. Soteria has authority to agree on behalf of Provider to the terms and conditions set forth in such Term Summary Sheets and the applicable Payor Contracts, subject to § 2F, and accordingly, Provider agrees to be bound by the terms and conditions set forth in such Term Summary Sheets and the applicable Payor Contracts. Such Term Summary Sheets will not be considered an amendment or modification of this Agreement.

2J. Use of Name. Provider agrees that his/her name, address, telephone, fax number, logo, web site address and type of practice may be included in a directory, brochure or listing of Soteria Providers provided by Soteria to its Payors and Beneficiaries and by Payors to Beneficiaries.

2K. Claims Billing. Unless directed otherwise by Soteria, all claims filed under Payor Contracts shall be filed by Provider to Soteria' and/or its designated claims management vendor within sixty (60) days of the date of service. Failure to forward claims for services to Beneficiaries to Soteria or Soteria' claims management vendor for proper review shall be cause for termination. Claims submitted later than sixty (60) days of the date services were provided shall be denied for payment. Provider agrees that he/she will submit claims for services rendered by him/her to eligible Beneficiaries. In no event, will Provider submit claims for payment to Soteria for services rendered by a non-participating, ineligible and/or non- credentialed Provider. Any such claims will be denied for payment and may result in immediate termination of Provider's participation in Soteria and other actions including reporting to proper agencies as deemed appropriate by Soteria' Board of Directors and/or UM/QM Committee.

2L. Primary Payor. Provider agrees that in the event that a patient has other insurances which would be considered the primary payor for services in accordance with standardly recognized insurance procedures, Provider agrees to submit charges for services to the primary payor prior to submitting charges for payment to Soteria as the secondary payor. This provision is subject to the provisions of State law.

2M. Utilization Management and Quality Assurance Programs. Provider agrees to comply, cooperate with, and abide by utilization management and quality assurance procedures and protocols as structured and approved by Soteria. Failure to obtain authorizations and/or provide requested documentation shall be cause for denial of payment of the claims. Provider shall not bill Beneficiary for services rendered which are denied for payment due to the services being deemed non-medically necessary unless the Beneficiary was informed prior to the services being rendered and agreed in writing to accept Financial responsibility for such services. From time to time, Provider may be asked to serve on a Soteria peer review committee to review documentation pursuant to Soteria cases involving Soteria Providers other than him/herself.

2N. Advertising. Provider acknowledges that Soteria disseminates brochures and other informational materials to prospective Payors and their eligible Beneficiaries and that the success of the Program is dependent on the maintenance of good relations with Soteria, Payors and Beneficiaries. During the term of this agreement, Provider shall not direct advertising or any solicitation to Payors or Beneficiaries, referring to Provider's standing with Soteria without first obtaining the written consent of Soteria.

2O. Provider agrees to abide by policies, Procedures and Requirements as outlined in Soteria's Provider Manual (i.e. "Owner's Manual") hereby included and incorporated by reference into this Agreement.

3. PARTICIPATION FEES.

3A. Amount. With respect to Provider participation under the terms of this Agreement, and notwithstanding Payor Contracts which may be exempt, Provider agrees to pay to Soteria a non-refundable credentialing fee and an annual membership fee in the amount as set forth by the Soteria Board of Directors from time to time. Applicable fees shall be payable upon submission of credentialing information and execution of the Agreement and an annual membership renewal fee thereafter due no later than December 31st each year.

3B. Failure to Pay. This Agreement may be terminated immediately by Soteria in the event Provider fails to pay any contribution as provided herein promptly when due.

3C. No Refund. No refund shall be made by Soteria of any portion of the participation fee paid by Provider if this Agreement is terminated by either party hereto at any time, or for any reason.

4. UTILIZATION MANAGEMENT.

4A. Payor Participation. To provide assurance to Payors that proposed services and health care services rendered by Soteria Providers is Medically Necessary, Soteria has incorporated utilization management as an integral part of the Program. When integrated into the Payor Contract, utilization management services shall be rendered by Soteria or its selected utilization management vendor or by a program selected by Payor, which has been approved to render such reviews.

4B. Provider Participation. Provider shall initiate utilization management of proposed treatments for Beneficiaries as directed by Soteria or Payor. Provider recognizes that payment may be disputed or denied by Payor or Soteria if Provider renders care beyond designated thresholds to a Beneficiary for whom utilization management as provided herein was not performed. Provider agrees to provide necessary information to the approved utilization management program regarding diagnosis, proposed treatment, prognosis and other information pertinent to the CHIROPRACTIC care being proposed or rendered by Provider to Beneficiary. Provider shall also initiate contact with the utilization management program in the event of a Beneficiary's utilization of referral for specialty diagnostic services, Including but not limited to, MRI, CT Scan, EMG, etc. or a medical or specialty consultation.

5. RECORDS AVAILABILITY.

5A. Records Maintained. Provider shall prepare and maintain appropriate and accurate medical and financial records concerning health care services rendered to Beneficiaries pursuant to this Agreement. Such records shall be maintained in a manner designed to safeguard Beneficiary privacy and confidentiality and in accordance with prudent, generally accepted record-keeping procedures, and as required by law. Provider shall maintain such records in accordance with all state and federal laws which currently require that records be maintained for a minimum of seven (7) years for adult patients and for seven (7) years following a minor child reaching the age of eighteen. Provider agrees to comply with all timeframes designated by state and federal laws regarding the maintenance of such records as may be amended from time to time. Provider shall permit access to and review and duplication of such records by Soteria or its designated representative. Such access, review and duplication shall be made without charge to Soteria and shall be allowed by Provider during regular business hours and upon reasonable notice by Soteria. Duplication of records shall be at Provider's expense.

5B. Continuing Confidentiality. Access to and duplication of such records by Soteria shall be subject to all applicable laws and regulations concerning the confidentiality of such records and Provider shall not be required by this agreement to provide access to or release from patient medical records any confidential information unless such release is authorized by statute, subpoena, court order, patient consent or other lawful means.

5C. Access. Subject to applicable laws and regulations relating to privacy and the confidentiality of patient records, Provider shall give Soteria access to records and data maintained by Provider that are necessary to determine Provider's performance under and compliance with this Agreement. Such access shall be without charge to Soteria and shall be allowed during regular business hours and upon reasonable notice by Soteria.

5D. HIPAA. Provider is a "covered entity," as that term is defined in the HIPAA Standards for Privacy of Individually Identifiable Health Information and the Standards for Security of Electronic Protected Health Information, 45 C.F.R. Part 160 and Part 164, Subparts A, C and E (the "HIPAA Regulations"), and, as such, must comply with the HIPAA Regulations. The HIPAA Regulations require Provider to enter into with its "business associates," as that term is defined in 45 C.F.R. § 160.103, an agreement containing certain minimum safeguards. Certain services Soteria provides under the Agreement will cause Soteria to be a business associate of Provider. Consequently, the parties will comply with the terms and conditions set forth in Exhibit B.

6. DISPUTES.

6A. Medical Necessity. All disputes which may arise relating to the medical necessity of health care or quality of services provided hereunder shall be submitted for resolution in accordance with the dispute procedures approved by Soteria' Board of Directors and/or provided under the terms of the contract entered into between Payor and Soteria and/or its approved utilization management organization. If the other parties to such dispute agree to be bound by such resolution, Provider agrees to be so bound.

6B. Cost. All disputes related to fees or charges for Health Care Services rendered by Provider hereunder to any Beneficiary shall be submitted for resolution pursuant to the dispute procedures established by the Board of Directors of Soteria. If the other parties to such dispute agree to be bound by such resolution, Provider agrees to be so bound. Such dispute procedures shall remain in effect for a period of one year after termination of this Agreement for the resolution of matters unresolved on the date of termination.

6C. Other Disputes. Other disputes concerning administrative and procedural issues under this Agreement may be submitted for resolution pursuant to dispute resolution procedures established by the Soteria Healthcare Board of Directors as the same may be adopted and communicated by Soteria to Provider from time to time. If the other Parties to such dispute agree to be bound by such resolution, Provider agrees to be so bound. Notwithstanding the foregoing, questions relating to quality of care, Medical Necessity of care and cost of care shall not be submitted for resolution pursuant to this subsection.

6D. Records. Provider shall provide to Soteria any and all records maintained by Provider that may be necessary for the resolution of disputes pursuant to the provisions of this Section.

7. SOTERIA SERVICES AND RESPONSIBILITIES.

7A. Promotional Services. Soteria will provide marketing and other promotional services on behalf of Soteria Providers to potential and existing Payors. Soteria shall carry out marketing responsibilities on behalf of Soteria Providers. Nothing contained herein, however, shall constitute a representation or warranty by Soteria as to the minimum level of marketing or other promotional services to be provided on behalf of Provider or any other Soteria Providers.

7B. Payor Contracts. Soteria will negotiate contracts with Payors and make best efforts to secure favorable terms on behalf of Soteria Providers. Soteria will administer the contracts with Payors.

7C. Incentives. Soteria shall develop and encourage Payors to implement incentives for Beneficiaries to use the services of Soteria Providers more frequently than Non-Soteria Providers. Incentives may include, but are not limited to: 1) health plan policy benefit incentives in the form of lower out- of-pocket expenses and increased percentage of benefits coverage and/or 2) communications and educational programs designed to create awareness of Soteria Providers and benefits of health care rendered by the specialties represented by Soteria Providers.

8. RELATIONS AMONG THE PARTIES.

8A. Independent Contractor. None of the provisions of this Agreement are intended to create, nor shall be deemed or construed to create, any relationship between Soteria and Provider other than that of independent entities contracting with each other hereunder solely for the purpose of effecting the provisions of this Agreement. Neither of the parties hereto, nor any of their respective employees, contractors or agents, shall be deemed or construed to be an agent, employee, partner, associate, or joint venture of the other for any purposes whatsoever.

8B. Professional Care. Provider shall maintain the doctor/professional-patient relationship with Beneficiaries and is solely responsible to Beneficiaries for the provision of Health Care Services. Soteria is not responsible for the provision of such care. Such relationship includes the right of Provider to commence or terminate treatment of Beneficiaries in accordance with generally accepted principles of sound practice and treatment. Nothing herein shall be construed to require Provider to commence or continue care or treatment by Provider or to require Beneficiaries to commence or continue treatment by Provider. Further, nothing in this Agreement is intended to

supersede or substitute for Provider's clinical judgment concerning the patient's best interests (including choice of consultants).

8C. No Liability. Neither Soteria nor any of its officers, directors, employees, agents or other representatives shall be liable or responsible in any way to any party or person for any act or omission of Provider in connection with the rendering by Provider of Health Care Services to Beneficiaries.

8D. Separate Contracts. This Agreement is entered into by Provider and Soteria with the express understanding and agreement that it shall not be construed or considered to be a contract between Provider and any other Soteria Provider, nor shall it constitute an agreement that Provider may act as agent for any other Soteria Provider or impose any liability upon any other Soteria Provider by reason of any act or acts of omission or commission on the part of the Provider, nor shall Provider incur any liability by reason of any act or acts of omission or commission of any other Soteria Provider.

8E. Further Acts and Documents. Each of the parties hereby agrees to execute and deliver such further instruments and do such further acts and things as may be necessary or desirable to carry out the purposes of this Agreement.

9. INDEMNIFICATION/HOLD HARMLESS.

9A. Provider shall defend, hold harmless and indemnify Soteria against any and all claims, liabilities, damages or judgments (including reasonable attorney's fees and litigation expense) asserted against or incurred by Soteria which may arise out of services provided, or to be provided by Provider under this Agreement or which may arise from the malpractice or negligence of Provider or Provider's employees in the discharge of its or their professional responsibilities to a Beneficiary. Within ten (10) days after receipt by Soteria of notice or knowledge of any claim or commencement of any action or proceeding by a third party against Soteria relating to Health Care Services provided by Provider, Soteria shall give Provider written notice of such claim or the commencement of such action or proceeding in such reasonable detail as Soteria possesses.

10. CONFIDENTIALITY.

10A. Records and Data. Confidential records and data supplied by Provider to Soteria under this Agreement shall be treated by Soteria as confidential and shall not be disseminated or published except as deemed necessary by Soteria to effect the purposes of Soteria or this Agreement. Soteria shall implement reasonable internal procedures intended to limit access to and guard against improper disclosure of such materials.

11. TERM AND TERMINATION.

11A. Term. The initial term of this Agreement shall commence on the effective date and shall expire on the December 31st first following the effective date. Unless earlier terminated as herein provided, this Agreement will be renewed automatically for successive one-year periods following the expiration of the initial term, unless terminated by either party as provided below.

11B. Termination By Either Party Without Cause. This Agreement may be terminated for any reason or no reason, with or without cause, by either party upon a minimum of sixty (60) days written notice to the other party. Unless immediate termination is required as outlined below, the effective date of termination requested by Provider shall be December 31 or June 30 of any calendar year and shall be the future date closest to the date of request for termination.

11C. Termination By Soteria for Cause. This Agreement may be terminated by Soteria for cause immediately upon written notice to Provider. The term "for cause" shall include, but shall not be limited to, the following: (1) Provider makes/furnishes false or misleading information to Soteria; (2) Provider's failure to comply with Soteria' reimbursement, referral, or authorization policies; (3) Provider's failure to remit Soteria Participation Fees as provided herein; (4) Provider's failure to comply with license requirements as provided herein; (5) Provider's failure to abide by Soteria' general, utilization management, claims processing/filing or quality assurance procedures and protocols (which shall also give Soteria the option to deny reimbursement); (6) Provider's failure to maintain adequate liability insurance as provided herein; (7) Provider commits professional misconduct, violates the principles of professional ethics or, in the determination of Soteria, has been subject to an excessive number of professional liability claims; (8) Provider acts or provides care in a manner which, in the determination of Soteria threatens potential serious injury to Beneficiaries or to the reputation of Soteria; or in a manner which may adversely affect the ability of Soteria to conduct business; (9) Provider is subject to an indictment or investigation for a felony or to any disciplinary action.

12. WAIVER.

Provider hereby consents to examination and evaluation of treatment given by Provider to any Beneficiary in connection with the utilization management and dispute resolution programs described in or provided by this Agreement. Provider hereby releases any person participating in such programs (including but not limited to Soteria and its employees and representatives, and Payor, Beneficiaries and Payors employees and representatives) from any claims and liabilities arising from or based upon actions taken, statements made or information given by such person in good faith and without malice.

13. MISCELLANEOUS.

13A. Headings. The headings or titles provided throughout this Agreement are for references purposes only and shall not in any way affect the meaning or interpretation of this Agreement.

13B. Amendments. Soteria may amend this Agreement from time to time as deemed necessary by the Board of Directors of Soteria, any amendment shall automatically become effective and a part of this agreement ten (10) days after written notice of the amendment is given to Provider. Provider may terminate participation pursuant to the terms outlined in Section 11.

13C. Assignment. Provider may not assign any of its rights or delegate any of its duties or obligations hereunder without the written consent of Soteria. Soteria may assign its rights or delegate any of its duties hereunder with notification provided to Provider via first class mail within ten (10) days of the effective date of such action authorized by the Soteria Board of Directors.

13D. Invalidity or Unenforceability. The invalidity or unenforceability of any terms or provisions hereof shall in no way affect the validity or enforceability of any other term or provision hereof.

13E. No Waiver. No waiver of any breach of any provision or condition of this Agreement by either party hereto shall be deemed to be a waiver of a similar or dissimilar provision or condition at any prior or subsequent time, or of the provision or condition itself.

13F. Proprietary Information. Provider agrees that procedures, policies, reimbursement schedules, and systems developed and established by Soteria in fulfilling its responsibilities under this Agreement and the identity of other Soteria Providers constitutes confidential information. Provider agrees that during the term of this Agreement and thereafter, Provider shall not disclose to any person or entity information confidential to Soteria.

13G. Non-Solicitation. Provider agrees that the business relationship established between Soteria and its Payors and the employer and Payor groups with which it contracts shall be deemed the property of Soteria. All lists of Payor Contracts shall be deemed the property of Soteria. During the term of this Agreement or any renewal thereof, and for a period of (one) 1 year from the date of termination, Provider agrees that Provider will not interfere with Soteria' contract and/or property rights; advise or counsel any Beneficiary or Payor group to disenroll from Soteria or its Payor Contracts; solicit such Beneficiary or Payor group to become enrolled with any other health maintenance organization; preferred provider organization or any other similar hospitalization or medical payment plan or insurance company; or disclose proprietary Soteria information.

13H. Non-Exclusive Agreement. Nothing contained in this Agreement shall prohibit or restrict Provider from affiliating with, or contracting to provide Health Care Services for any other health care delivery organizations.

13I. Entire Agreement. This Agreement contains the entire agreement of the parties with respect to the subject matter hereof and supersedes any prior agreements, understandings, negotiations or representations, whether written or oral, between the parties.

13J. Governing Law. This Agreement shall be governed by, construed and enforced in accordance with the laws of the State of Georgia.

13K. No Third Party Beneficiary. Notwithstanding that benefits may inure to Payors and Beneficiaries under this Agreement, it is not the intention of Soteria or Provider that such Beneficiaries shall be third party beneficiaries of the obligations assumed by either party to this Agreement, except as provided for in Payor Contracts, and no such Beneficiaries shall have the right to enforce any such obligation.

13L. Pre-Existing Contract With Payors. Provider agrees that if Provider has a pre-existing contract with a Payor (either directly or through a network relationship) with whom Soteria enters into a Payor Contract, the Payor Contract and the Provider obligations hereunder pursuant to this Agreement supersede any and all obligations under Provider's pre-existing contract with that Payor.

13M. Communication. Provider recognizes the importance of timely communication with Soteria and accordingly gives Soteria permission to communicate with Provider via facsimile and/or e-mail to communicate Soteria information.

13N. Severability. In the event of the unenforceability or invalidity of any paragraph or provision of this Agreement, such paragraph or provision shall be enforceable in part to the fullest extent permitted by law, and such invalidity or unenforceability shall not affect any other paragraph or provision of this Agreement, and this Agreement shall otherwise remain in full force and effect.

13O. Notices. All notices and other communications provided for by this Agreement shall be in writing and shall be personally delivered or sent by first class certified mail, postage prepaid to the following address:

SOTERIA: Soteria Healthcare Network, Inc.
4080 McGinnis Ferry Road, Bldg 800, Suite 801
Alpharetta, Georgia 30005
TEL. 770-455-8190

PROVIDER:
[At the Address Listed on the Signature Page of This Agreement]

Notices shall be deemed provided when personally delivered or seventy-two (72) hours after the date mailed.

EXHIBIT A

SOTERIA HEALTHCARE TERM SUMMARY SHEET Network:
Product:
Term of Agreement:

Withhold Percentage: (If Applicable)

PCP Referral:
Utilization Management: Verification of Eligibility:

Group Health/Worker's Compensation:

Reimbursement Terms: Claims Filing: Encounter Reporting:

Note:

This document is a summary only of certain aspects of the Payor Contract in question. A copy of The Payor Contract will be made available upon written request to Soteria Healthcare by Provider. Pursuant to Sections 2F and/or 2I of the Provider Agreement, Provider agrees to be bound by the terms and conditions of the Payor Contract in question.

EXHIBIT B

This Exhibit B sets forth the terms governing the parties' business association created by the Agreement.

1. Definitions. Except as otherwise set forth in the Agreement, all capitalized terms in this Exhibit B have the same meaning as set forth in the HIPAA Regulations, as such may be amended from time to time.
a) "Disclose" has the same meaning as the term "disclosure" in 45 C.F.R. § 160.103.
b) "EPHI" has the same meaning as the term "electronic protected health information" in 45 C.F.R. § 160.103, but limited to information created or received by Soteria as a Business Associate of Provider;
c) "PHI" has the same meaning as the term "protected health information" in 45 C.F.R. § 160.103, but limited to information created or received by Soteria as a Business Associate of Provider.
d) "Secretary" means the Secretary of the Department of Health and Human Services or his or her designee.

2. Soteria's Obligations. Soteria will:
a) Not Use or Disclose PHI except as permitted or required by this Exhibit B or as required by law;
b) Use appropriate safeguards to prevent the Use or Disclosure of PHI, except as set forth in this Exhibit B;
c) Implement Administrative, Physical and Technical Safeguards that reasonably and appropriately protect the Confidentiality, Integrity and Availability of EPHI;
d) Report to Provider: (i) any Use or Disclosure of PHI by Soteria that is not contemplated by this Exhibit B and (ii) any Security Incident, of which Soteria becomes aware;
e) Ensure that any agents, including subcontractors, to whom Soteria provides PHI agrees to the same restrictions and conditions in the Agreement and this Exhibit B;
f) In accordance with Provider's reasonable request, provide Provider, in accordance with 45 C.F.R. § 164.524, access to PHI in a Designated Record Set;
g) Make any amendment to PHI in a Designated Record Set that Provider has agreed to pursuant to 45 C.F.R. § 164.526;
h) Document any Disclosures of PHI necessary to provide an accounting of Disclosures in accordance with 45 C.F.R. § 164.528;
i) Make its internal practices, books and records, relating to the Use and Disclosure of PHI available to the Secretary for purposes of determining Provider's compliance with the HIPAA Regulations.

3. Permitted Uses and Disclosures. Except as otherwise set forth in this Exhibit B, Soteria may:
a) Use or Disclose PHI to perform its duties and obligations in the Agreement; provided that, such Use or Disclosure complies with the HIPAA Regulations;
b) Use PHI for its management and administration or to carry out Soteria's legal responsibilities;
c) Disclose PHI for the purposes in Section 3(b) of this Exhibit B, if (i) the Disclosure is required by law, or (ii) Soteria obtains reasonable assurances from the persons to whom the PHI is disclosed that (x) the PHI will remain confidential and will not be Used or further Disclosed except as required by law or for the purpose for which it was Disclosed to the person, and (y) the person will notify Soteria of any instances of which it becomes aware that the confidentiality of the PHI has been breached.

4. Provider's obligations. Provider will notify Soteria of any:
a) Limitation in Provider's Notice Of Privacy Practices, as required by the HIPAA Regulations, that may affect Soteria's Use or Disclosure of PHI;
b) Changes in or revocation of an individual's permission to Use or Disclose PHI, to the extent such change may affect Soteria's Use or Disclosure of PHI; and
c) Restriction regarding the Use or Disclosure of an individual's PHI that Provider has agreed to in accordance with 45 C.F.R. § 164.522, to the extent that such restriction may affect Soteria's Use or Disclosure of the PHI.

5. Effective Date. The terms and conditions in this Exhibit B will be effective as of the effective date of the Agreement and will continue until all PHI is destroyed or returned to Provider.

6. Termination. Notwithstanding any provision to the contrary, if Soteria materially breaches the terms of this Exhibit B, Provider will provide Soteria a reasonable opportunity to cure the breach or end the violation. If neither termination nor cure are feasible, Provider will report the violation to the Secretary.

7. Effect of Termination. Except as otherwise provided in the Agreement, upon termination of the Agreement, Soteria will return to Provider or destroy all PHI. If it is not feasible for Soteria to return or destroy the PHI, (i) Soteria will notify Provider of such infeasibility; (ii) Soteria will limit Soteria's Use and Disclosure of such PHI to the purpose which makes it infeasible for Soteria to return or destroy the PHI; and (iii) the terms and conditions set forth in this Exhibit B will continue with respect to the PHI for so long as Soteria maintains the PHI.

SOTERIA HEALTHCARE NETWORK®

First & Last Name of Provider: ______________________________

SECONDARY PRACTICE LOCATION(S) DETAILS | SECTION 16

Do you currently practice at this location (listed below)? ____ Yes _____ No Start Date (mm/yy) ______________________

Primary Practice Name: ____

Practice Full Address: ____

City ______________________ State ________ County____________________ Zip ________________

Mailing Address (if different from above) ____

Office Tel. ______________ Office Fax: ______________ Office Email: ______________________

Appointment Scheduling Web Site: ____

Can general correspondence be sent to this address? (Check Box) ____Yes _____No (If no, please provide address and fax on the line below)

Practice Setting (Check Box) _____GROUP _____ SOLO

If you are not currently in practice, please describe your intentions regarding beginning and/or reinstating your practice:

____

Does this office qualify as a minority owned business enterprise? (Check box) _____Yes _____ No

Do you have an organization NPI #-Type 2) ____ Yes ____ No NPI (Type 2) # ______________________

Medicaid Group Number: ________________ Medicare Group Number: ______________________

Phone Number: ________________ Fax #________________ Back Office Tel. ________________

Do you have 24 hour /7 day a week phone coverage available? _____ Yes _____ No

If yes, indicate type of coverage arrangements. ____

⇒ At this location, I provide service(s) to patients within _______ hours OR, _______ days for emergency/urgent needs.

⇒ At this location, I provide service(s) to patients within _______ hours OR, _______ days for routine/maintenance care.

⇒ **AM HOURS:** _______ Mon _______ Tues _______ Wed _______ Thurs _______ Fri _______ Sat _______ Sun

⇒ **PM HOURS:** _______ Mon _______ Tues _______ Wed _______ Thurs _______ Fri _______ Sat _______ Sun

⇒ Do You or your Staff Speak Any Languages Spoken Other Than English, including ASL (Describe) ______________________

⇒ Do you take history, physical and x-rays at the initial visit for all patients? ___ YES or NO ___

⇒ Do you routinely prepare a written Plan of Treatment during your initial history and physical? ___ YES or NO ___

⇒ On-Site X-Ray ___ YES or NO Make: ________________ Model: ________________ Size Unit: __________ KV: _______ MA: ______

⇒ Year Manufactured: ___________ Table Bucky: ____Wall Bucky: ____ Date of Last State X-Ray Certification: ________________

Tax Information | SECTION 16 A

Practice Name as it appears on W-9 ____

Tax ID: ________________ Provider Directory Classification Type: ___ Acupuncture ___ Chiropractor ___ Massage Therapy

Based on your contracted agreement, do you wish to be listed in the Directory under your primary specialty? ___ YES or NO ___

Patients | SECTION 16 B

Do you accept new patients at this location? ____ Yes ____ No

Do you accept existing patients with change of payor at this location? ____ Yes ____ No

Do you accept all new patients at this location? ____ Yes ____ No

Do you accept new Medicare patients at this location? ____ Yes ____ No

Do you accept new Medicaid patients at this location? ____ Yes ____ No

Do you accept new patients from chiropractor/physician referral **only**? (i.e. referring letter) ____ Yes ____ No

Colleagues At This Location Include | SECTION 16 C

Do you have any Partners/Associates at this location? Note, if Group Practice, please list the names (first and last) of all of the other providers also practicing at this location.

____

Do you have any massage therapists, nutritionist, dieticians, acupuncturists at this location? ____ Yes ____ No

(If yes, please include contact info below)

Type of Provider: _____ Massage Therapist _____ Acupuncturist _____ Nutritionist/Dietician

First name: ______________________ Last Name: ______________________ Middle Initial: __________

Phone Number: ______________________ Ext. ______________Fax Number: ______________________

Email: ______________________________________ Is Office Manager Credentialing Contact: ___Yes ___ No

Credentialing Contact (If different from Office Manager) Full Name ______________________ Tel. ________________

SOTERIA HEALTHCARE NETWORK

First & Last Name of Provider: ______________________________

Billing Contact Information | SECTION 16 D

Name of Off ice Manager/Administrative Contact: ______________________________

Office Manager Tel. ____________________ Office Manager Email ______________________________

Payment and Remittance SECTION 16 E

Billing Representative Name ______________________________ Tel. ____________________ Ext. __________

Other Limitations: ______________________________

Accessibility | SECTION 16 F

Does this office provide handicapped accessibility? (Check box) ____ Yes _____ No

Do you provide handicap accessibility for each of the following areas?

Exterior Building ____Yes _____No
Interior Building ____Yes _____No
Wheelchair access to exam room ____Yes _____No
Exam table/scale/chair ____Yes _____No
Parking ____Yes _____No
Restroom ____Yes _____No

Does this location have other services for the disabled?

American Sign Language (ASL) ____Yes ____No
Mental/Physical Impairment Services ____Yes ____No
Other disability services ____Yes ____No
Is this office accessible by public transportation? ____Yes ____No
If Yes, indicate type of transportation: ____________________

Does this office meet all state and local fire, safety and sanitation requirements? ____Yes ____No
Do you accept Workers Compensation Patients? ____Yes ____No
Are staff trained in identification and care of patients with work-related illness/injury and provide care/services with an active return to work philosophy? ____Yes ____No
Modified or alternative duty is actively evaluated for each workers' Compensation claimant? ____Yes ____No

Office will accommodate urgent walk-ins (or non-urgent appointments within 48-hours) to treat injured or ill workers and facilitate their return to work, if possible, Staff are available and willing to provide compensation representatives information regarding a claimant's care. ____Yes ____No

Services | SECTION 16 G

Does this location provide any of the following services:

Laboratory ____Yes ____No
Radiology ____Yes ____No
Allergy Injections/Skin Testing ____Yes ____No
X-Ray On Site ____Yes ____No
EKG Testing ____Yes ____No
Pulmonary Function Testing ____Yes ____No
Tympanometry/Audiometry Screening ____Yes ____No
Physical Therapy Services ____Yes ____No

Additional Office Procedures Not Listed Above, Please Describe ______________________________

Is anesthesia administered in your office? ____Yes ____No

If yes, anesthesia administered by: (First and Last Name) ______________________________

What class/category of anesthesia is used? ______________________________

What emergency equipment is available? ______________________________

Certifications (Do you or someone in your office have the following additional certifications?) | SECTION 16 H

BLS – Basic Life Support: ___ Yes ___ No ____________ Expiration
ACLS – Advanced Cardiac Life Support: ___ Yes ___ No ____________ Expiration
ALSO – Advanced Life Support in OB: ___ Yes ___ No ____________ Expiration
PALS – Pediatric Advanced Life Support (Classification) ___ Yes ___ No ____________ Expiration
ATLS – Advanced Trauma Life Support (Certified) ___ Yes ___ No ____________ Expiration
CPR – Cardio-Pulmonary Resuscitation Classification: ___ Yes ___ No ____________ Expiration
Other (please specify): ______________________________ - ____________ Expiration