801-999-0382
1192 Draper Parkway #313 Draper, UT 84020
rod.impulsesolutions@gmail.com
www.impulsesolution.c om

FEE CONTRACT

THIS IS AN AGREEMENT between

_____
__, hereafter referred to as "Client," and Impulse Solutions LLC, hereafter referred to as "Impulse Solutions" a Utah LLC that resides at 1192 Draper Parkway #313 Draper, UT 84020.

1. Matter Covered:
Client retains Impulse Solutions to represent Client in connection with Emergency Room Billing and or Medical procedure that occurred on/between _____.

2. Services to be Performed by Impulse Solutions:
Impulse Solutions agrees to perform the advocate services reasonably required to possibly reduce Client's personal Emergency Room Billing and/ or Medical procedure. A certified letter detailing all findings will be provided. This letter can then be provided to the billing source of the client's. No other services are covered by this Agreement. Thus, if the judgment is unsatisfactory to Client, Impulse Solutions shall not be obligated to render services in connection with further investigation of the Client's Emergency Room Billing and/ or Medical procedure ; nor shall Impulse Solutions be obligated to render services on appeal or in proceedings to enforce the judgment. Impulse Solutions is not authorized to associate and employ other counsel to assist in representing Client.

3. Services to be Performed by Client:
Client shall provide Impulse Solutions with the following:
1) Itemized bill for the billing that is in question and in need of review.
2) medical documentation that includes and that is related to the said questioned bill.
3) Insurance statements that are related to the said bill in question.
4) Summary of Benefits from insurance carrier(s) that includes and that is related to the said questioned bill.

The client understands that without this information that Impulse Solutions will not provide our services. Initial_____

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4. No Guarantee as to Result:
Client acknowledges that Impulse Solutions has made no guarantee as to the outcome or amounts recoverable in connection with Client's claim.

5. Advocacy Costs and Expenses:
Impulse Solutions will be reimbursed by Payment of $100.00 per ER visit that is reviewed before any advocacy of ER bill by Impulse Solutions. If there is no recovery on the Client's bill, Impulse Solutions will not bear any loss. Costs include, but are not limited to, consultant and expert fees and expenses, investigation costs, long-distance telephone charges, messenger service fees, photocopying expenses, and process server fees. Items that are not to be considered costs, and that must be paid by Client without being either advanced or contributed to by Impulse Solutions, include, but are not limited to, Client's medical expenses and other parties' costs, if any, that Client is ultimately required to pay.

6. Client Acknowledgment:
Client acknowledges having read all of the terms and conditions set forth in this Agreement and that he/she fully understands and agrees to same. Initial _____

7. Discharge of Impulse Solutions:
Client may discharge Impulse Solutions at any time by written notice effective when received by Impulse Solutions. Unless specifically agreed by Impulse Solutions and Client, Impulse Solutions will provide no further services and advance no further costs on Client's behalf after receipt of the notice. Notwithstanding the discharge, Client will be obligated to pay Impulse Solutions out of the recovery a reasonable attorney's fee for all services provided and to reimburse Impulse Solutions out of the recovery for all costs advanced. If there is no recovery Impulse Solutions will bear the loss.

8. Withdrawal of Impulse Solutions:
Impulse Solutions may withdraw at any time as permitted. The circumstances under which the Rules permit such withdrawal include, but are not limited to, the following: (a) The client consents, and (b) the client's conduct renders it unreasonably difficult for Impulse Solutions to carry out the employment effectively. Notwithstanding Impulse Solutions's withdrawal, Client will be obligated to pay Impulse Solutions out of the recovery a reasonable fee for all services provided, and to reimburse Impulse Solutions out of the recovery for all costs advanced, before the withdrawal. If there is no recovery Impulse Solutions will not bear the loss.
CLIENT'S SIGNATURE
_____
SIGNATURE Impulse Solutions,

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AUTHORIZATION FOR RELEASE OF INFORMATION

To:
Re: Emergency Room Visit and Billing
Client:_____
Date of Visit:_____ _____
Date of Birth:_____
Social Security #:_____

This will authorize you to make disclosures and to give to Impulse Solutions LLC 1192 Draper Parkway #313 Draper, UT 84020 (801) 999-0382, or its representative, orally or in writing, by photocopy or otherwise as requested, any and all information pertaining to the undersigned including protected information.
This authorization is in compliance with the privacy provisions of HIPAA (Health Insurance Portability and Accountability Act) and the GLB (Gramm Leach Bliley Act).

1) I understand that the information used or disclosed may be subject to redisclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

2) I may revoke this authorization by notifying Impulse Solutions LLC or its representative in writing of my desire to revoke this
authorization.

3) I understand that any action already taken in reliance on this authorization can not be reversed, and my revocation will not affect those actions.

4) If this authorization is furnished to a medical provider, that medical provider may not condition its treatment of me on whether or not I sign the authorization.

5) This authorization automatically expires one (1) year after the date it is signed or upon the time that I revoke this authorization in writing.

6) The purpose of the records request is at the request of the individual.

DATED:_____

CLIENT'S SIGNATURE_____ _____

HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

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To:
Re: Emergency Room Visit and Billing
Client:_____
Date of Loss:_____
Date of Birth:_____
Social Security #:_____

This will authorize you to make disclosures and to give Impulse Solutions LLC 1192 Draper Parkway #313 Draper,UT 84020 (801) 999-0382 or their representative(s), orally or in writing, by photocopy or otherwise as requested, any and all information pertaining to the undersigned including protected information. Records are requested for the purposes of investigating and proving the legal claims as stated above. This authorization is in compliance with the privacy provisions of HIPAA (Health Insurance Portability and Accountability Act) and the GLB (Gramm Leach Bliley Act).

I agree that photocopies of this release including facsimiles shall be afforded the same evidentiary weight as the original.

I request that all my records be released in your possession, including, but not limited to:

X Inpatient Records; any and all dates requested.
X Outpatient Records; any and all dates requested.
X Medical History & Physical Exam
X Psychiatric/Psychological Evaluation
X Lab Reports/Tests
X Pathology
X Consults
X Physician Orders
X Emergency Room Records; any and all dates requested.
X Physician Office/Clinic; any and all dates requested.
X Progress Notes
X Discharge Summary/Instruction
X Operative Report
X Medication Records
X Radiology Records
X Mammography Report

HIV, Behavioral Health and Drug and Alcohol Information obtained in parts of the records indicated above will be released through this authorization unless otherwise indicated.
DO NOT RELEASE: □ HIV □ Behavioral Health (Psychiatric) □ Drug and Alcohol

I understand the following:

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That my health record(s) will not be released or obtained by Impulse Solutions or their representatives unless permission is provided for herein as evidenced by the signature on this Authorization for Release of Protected Health Information.

- That the release of my health record(s) will be for the purpose stated on this Authorization, and only those items indicated will be released.
- That the health record(s) released by the facility/person authorized above may possibly be re-disclosed by Impulse Solutions or their representatives that receives the record(s) and therefore (1) its staff/employees have no responsibility or liability as a result of the re-disclosure and (2) such information would no longer be protected by the Privacy Rule.
- That this Authorization is in effect for a period of 1 year from the date of signature, unless a specific time frame is documented; however, no time frame specified shall go beyond one year from the date of signature.
- That I may revoke this authorization by notifying you and/Impulse Solutions LLC 1192 Draper Parkway #313 Draper,UT 84020 (801) 999-0382, or their representative in writing of my desire to revoke this authorization.
- That my decision to revoke the Authorization does not apply to the release of my health record(s) that may have taken place prior to the date of my request to revoke the Authorization.
- That medical provider that this authorization is furnished to may not condition its treatment of me on whether or not I sign the authorization.
- That I am entitled to a copy of the completed Authorization form.

DATED:_____

CLIENT'S SIGNATURE:_____ ___