

Welcome to



We are excited to introduce you to our different approach to patient centered health care. But before we begin, please carefully read, fill out, and sign all parts of the following paperwork.

# Confidential Patient Information

NAME: \_\_\_\_\_ GENDER:  Male  Female  
Last First Middle Initial  
ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
E-MAIL: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SS#: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

**HIPAA Phone Authorization:** I authorize Head 2 Toe Spine & Sports Therapy to leave messages on my voicemail in regards to information regarding appointments, treatment related issues, and billing issues, **at the following phone number(s) checked below (you must specify at least one):** **Cell Phone Carrier:** \_\_\_\_\_  
 Home: ( \_\_\_\_\_ ) - \_\_\_\_ - \_\_\_\_  Cell: ( \_\_\_\_\_ ) - \_\_\_\_ - \_\_\_\_  Work: ( \_\_\_\_\_ ) - \_\_\_\_ - \_\_\_\_

**HIPAA Phone Authorization Other Than Patient:**  
I authorize Head 2 Toe Spine & Sports Therapy to leave a message for, or speak to the specified individual(s) listed below in regards to information regarding appointments, treatment related issues and billing issues (this person must provide us with your date of birth): *You have the right to withdraw this authorization at any time. Revocation must be submitted in writing.*  
**Name of Authorized Individual:** \_\_\_\_\_ **Their phone #:** ( \_\_\_\_\_ ) - \_\_\_\_ - \_\_\_\_

EMPLOYER: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_  
PRIMARY PHYSICIAN: \_\_\_\_\_ PHYSICIAN'S OFFICE: \_\_\_\_\_  
EMERGENCY CONTACT (not living with you): \_\_\_\_\_ PHONE: ( \_\_\_\_\_ ) - \_\_\_\_ - \_\_\_\_  
WHO MAY WE THANK FOR REFERRING YOU HERE TODAY? \_\_\_\_\_

## CONSENT TO USE OR DISCLOSE HEALTH INFORMATION FOR PURPOSE OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS & FINANCIAL AGREEMENT:

**HIPAA** I hereby authorize *Head2Toe Spine & Sports Therapy* to use and disclose the health & medical information, via fax, mail or electronically for the purpose of treatment, payment and Health Care Operations. I also authorize the physician to release any information to referring/consulting physicians or other health care providers, as your physician deems appropriate to facilitate my/our care. I hereby assign payment to be directly issued to *Head2Toe Spine & Sports Therapy* for any benefits available under my coverage and/or settlement for treatment and/or expenses incurred at this office. I agree that this Assignment of Benefits and Authorization to release information is irrevocable and that I am waiving the statute of limitations for payment. I have been informed of the \$20 fee on checks returned. In the event the account goes to collection I agree to pay interest, collection fees, and should legal action be filed, reasonable attorney fees, filing fees and any other costs involved in the collection process. I agree that I will not withhold/delay payment, and that I am responsible for my/my child's bill. **I understand that I am responsible for knowing my medical benefits/limits/exclusions.**

**WAIVER FOR PAYMENT OF NON-COVERED OR EXCLUDED MEDICAL SERVICES:** Non-covered or excluded medical services are identified in the information your health care plan provided to you. Additional examples of non-covered services may include: "maintenance or palliative care" chiropractic treatment(s), manual traction, trigger point therapy, exercise instruction, re-exams, medical equipment, supplements, and treatment without a referral and/or authorization. Labor & Industries does not cover supplies. I understand that there may be certain procedures / supplies/charges that are not covered by my insurance/3rd party settlement, and agree that I am financially responsible for those charges.

**CONSENT TO TREATMENT OF A MINOR:** As parent or legal guardian, I have the authority to authorize, and do hereby grant the Chiropractors and Certified Licensed Athletic Trainers at Head 2 Toe Spine & Sports Therapy to administer chiropractic and other care as deemed necessary by the above mentioned individuals at Head 2 Toe Spine & Sports Therapy to my son/daughter/ward.

## PRINT PARENT/LEGAL GUARDIAN NAME:

My signature below acknowledges that I have reviewed, understand and agree to the HIPAA phone authorization, authorization to release information/assignment of benefits, financial policy, waiver for payment of non-covered/excluded services, and (if applicable) consent to the treatment of a minor. By refusing to sign, I understand that I (or my child) will not be able to receive care in this office.

**Printed Patient/Legal Guardian Name:** \_\_\_\_\_

**Patient/Legal Guardian Signature:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

## Informed Consent

I, the undersigned, have voluntarily requested that Dr. Angelina Armstrong/Dr. Bruce Harris assist me in the management of my health concerns. I have understood and agree to all policies and terms provided in the Office Policies and Procedures. I understand that Dr. Armstrong and Dr. Harris are chiropractors and that their services are not to be construed or serve as a substitute for standard medical care. Dr. Armstrong and Dr. Harris recommend that I undergo regular routine medical check-ups by my medical doctor.

Medical doctors, doctors of chiropractic, osteopaths, and physical therapists who perform manipulation are required by law to obtain your informed consent before starting treatment.

I \_\_\_\_\_ (*print patient name*), do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving the movement of the joints and soft tissues. Exercise and nutritional counseling may also be used.

Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

**Soreness:** I am aware that like exercise, it is common to experience muscle soreness in the first few treatments. Active Release Technique may occasionally leave slight bruising and tenderness.

**Dizziness:** Temporary symptoms like dizziness and nausea can occur but are relatively rare. Please inform your doctor if you experience these symptoms.

**Fractures/Joint Injury:** I further understand that in isolated cases underlying physical defects, deformities, or pathologies like weak bones from osteoporosis, may render the patient susceptible to injury. When osteoporosis, degenerative disk, or other abnormally is detected, this office will proceed with extra caution.

**Stroke:** Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in one million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

A thorough health history and tests have been performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

**Treatment Results:** I also understand that there are beneficial effects associated with these treatments procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits.

I realize that the practice of medicine as well as chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. I agree to the performance of these procedures by my doctor and such other persons of the doctor's choice.

## Available Alternative Treatments

Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.

**Medications:** Medication can be used to reduce pain or inflammation. I am aware that long term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side-effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

**Rest/Exercise:** It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat, or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of great value, but are not corrective of injured nerve and joint tissues.

**Surgery:** Surgery may be necessary for conditions such as joint instability or serious disk rupture, among others. Surgical risks may include unsuccessful outcome, complications, pain or reactions to anesthesia, and prolonged recovery.

**Non-treatment:** I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment, making future recovery and rehabilitation more difficult and lengthy.

I have read and or have had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

**To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.**

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Patient/Guardian Name (Printed)

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Patient/Guardian Signature

Date

## Head2Toe Spine & Sports Therapy Cancellation/ No Show Policy

If you are unable to keep your scheduled appointment we require a **24 hour advance notice**. Failure to provide this notice will result in a **\$75.00 cancellation/ no show fee**.

If you have scheduled and cancelled a New Patient appointment more than 2 times, a credit card will be charged \$150 to book your next appointment, if the appointment is kept, we will refund you the \$150 at the time of your appointment. If the appointment is missed, we will keep the \$150 and no longer schedule future appointments.

You will be required to pay this prior to your next appointment, unless other arrangements have been made. This fee cannot be billed to your insurance company; you are solely responsible for its payment.

*We have adopted this policy for the following reasons:*

- Consistency is crucial for your success in building progress and maintaining results
- Multiple cancellations in your chart maybe considered non-compliant for insurance related visits and may invalidate your claim making reimbursement/settlement difficult
- We try to offer appointment times that are the most convenience for our clients and any blocked off time could have been available for others
- We staff our center based on the number of scheduled appointments

**I am aware of the cancellation policy and realize that I will be charged \$75.00 for all future missed appointments not cancelled 24 hours in advance.**

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Patient/Guardian Name (Printed)

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Patient/Guardian Signature

Date

## Head2Toe Spine & Sports Therapy Billing Procedures (2014)

1. Co-payments are due at the time of service. Deductible/co-insurance will be billed to you monthly and will reflect your balance.
2. A re-bill fee of \$2.00 will be applied to accounts 90 days past due and that have a minimum balance of \$7.00. If the account balance reaches a level where the re-bill fee is greater than \$2.00, then a percentage of 12% per year (or 1% per billing cycle) will be added to the account balance.
3. Your account will be sent to collections if your balance has not been paid for 120 days, even with our efforts to contact you.
4. With the exception of unexpected emergencies, we require that you notify us at least 24 hours in advance as to any appointment changes. Missed appointments are NOT billed to insurance. Missed appointments are billed to you directly at the \$75 'No Show' rate. If you miss/cancel 3 appointments without ample notice, we have the right to refuse to schedule you for any future appointments.
5. We will bill your PRIMARY insurance every day that you are receiving care in this office with the exception of Medicare/ Medicaid. However, if you have secondary insurance coverage, we will still collect your primary co-pay. We then will credit your account once we receive payment from the secondary insurance. Please note we must receive an EOB from the primary insurance before we can send a bill to your secondary insurance.
6. Our office will NOT enter into a dispute with your insurance company over your claim. This is your responsibility and obligation.
7. Services are due and payable at the time they are rendered unless other arrangements are made.
8. Our office will do an insurance verification as a courtesy. We cannot guarantee coverage or payment by your insurance company. It is your responsibility to know your insurance benefits.

**If you understand and agree to our billing policy, please sign your name below and we will bill your insurance**

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Patient/Guardian Name (Printed)

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Patient/Guardian Signature

Date