Spinal Health & Rehab
Integrative Medicine

INFORMED CONSENT

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working toward the same objective. It is important that each patient understand both the objective and the method that will be used to attain this objective. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks, and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. Health is a state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of the nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

- All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction.
- The benefits, risks, and alternatives of chiropractic care have been thoroughly explained to me to my complete satisfaction.

"I have read and fully understand the above statement and therefore accept chiropractic care on this basis."

PRINT NAME:_____

SIGNATURE:_____ **DATE:**_____

PREGNANCY RELEASE

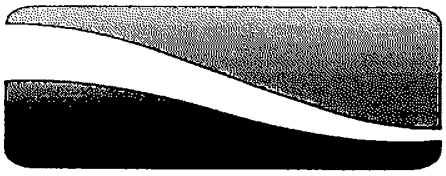
This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of Last Menstrual Cycle:_____

SIGNATURE:_____ DATE:_____

WITNESS (Please print):_____

WITNESS SIGNATURE:_____ DATE:_____



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OFFICE FINANCIAL POLICY

OUR POLICY IS TO EXTEND TO YOU THE COURTESY OF ALLOWING YOU TO ASSIGN YOUR INSURANCE BENEFITS DIRECTLY TO US. THIS POLICY REDUCES YOUR OUT-OF-POCKET EXPENSE AND ALLOWS YOU TO PLACE YOUR FAMILY UNDER CARE.

1. IF YOU DO NOT HAVE INSURANCE: All payments are expected at the time of service or by an authorized payment plan. Your personal balance may not exceed $100.00 at any time or care may be terminated. Our payment plans make chiropractic care an affordable part of your family's budget.

2. IF YOU DO HAVE INSURANCE: All deductibles and co-payments are expected at the time of service or by an authorized payment plan. Your co-insurance balance may not exceed $100.00 or care may be terminated. Our payment plans make chiropractic care an affordable part of your family's budget.

You are considered a cash patient until you bring in your completed insurance forms, and we qualify and accept your insurance coverage.

Our fees are considered usual, customary, and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area.

If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you then accept responsibility for payment in full of any outstanding balance and authorize us to use your credit card to collect full payment.

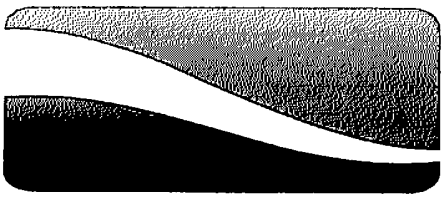
For self-pay patients with no major medical insurance, payment for rendered treatment is due at time of service. If a balance exceeds 3 days, **you authorize us to run the credit card on file for payment in full.**

When your schedule of visits is one per month or longer, you will not be eligible for insurance assignment if you have a Medicare policy. Charges for services rendered will be due as they are rendered or by an authorized payment plan.

If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claim submitted.

PATIENT'S PRINTED NAME:_____

SIGNATURE:_____ DATE:_____



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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I acknowledge that I received Spinal Health and Rehab's Notice of Privacy Practices for protected health information and that I have read it or declined the opportunity to read it and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

_____

Patient Name (please print)

_____

Parent, Guardian, or Patient's legal representative

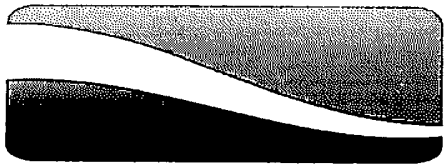
_____ _____

Signature Date

I, _____, authorize _____ to contact Spinal Health and Rehab regarding any information relative to my healthcare at Spinal Health and Rehab. Spinal Health and Rehab may also contact this person at (___)_____ in case of an emergency regarding my care. Written notice is required to change and/or delete this authorization.

_____ _____

Signature Date



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CANCELLATION AND NO-SHOW POLICY

Dear Patient(s),

We value our patients, and we are committed to the treatment of the whole patient, not just the illness. When we schedule appointments, we set aside time and professional resources to meet the individual needs of our patients, including time for one-on-one.

When a patient fails to show up for an appointment, or to cancel within 24 hours of the appointment, our valuable resources are idle. Most importantly, an opportunity is missed to schedule other patients. This courtesy allows our office to schedule another patient who is in need of medical care.

We have implemented a new policy in our practice called No-Call/No-Show, this will allow our office to charge you $35.00 for no notice of cancellation, per appointment. Due to the high volume of No-Call/No-Show appointments, we implemented this policy.

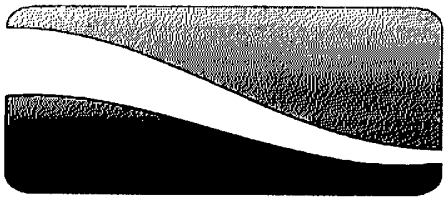
By signing below you understand the importance of calling within 24 hours to reschedule or cancel an appointment. Please understand we will bill you directly the $35.00 No-Call/No-Show fee, not your insurance carrier. If you have any questions, please call our office.

Sincerely,
Spinal Health & Rehab Integrative Medicine

Patient Name:_____

Patient Signature:_____

Date:_____



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ASSIGNMENT OF BENEFITS AND MEDICAL RELEASE

Assignment of Benefits:

I, _____, hereinafter ASSIGNOR, hereby authorize

(Name of Insured Person)

_____ to pay directly to SPINAL HEALTH & REHAB of Punta Gorda.

(Insurance Company)

Hereinafter ASSIGNEE, the medical benefits otherwise payable to me for their services but not to exceed the charges of those services. I hereby ASSIGN to ASSIGNEE any benefits or causes of action under any policy of charges provided by ASSIGNEE. This Assignment of Benefits is given in exchange for ASSIGNEE agreeing to send request for payment to the above named insurance carrier for all payments due and payable pursuant to the ASSIGNOR'S contract of insurance. This Assignment of Benefits is IRREVOCABLE unless subsequent revocation is in writing and agreed to by both parties.

MEDICAL RELEASE

This document shall be sufficient to authorize any person having records of medical treatment, services, or supplies pertaining to me, to release true copies of the same to ASSIGNEE or any insurer providing coverage to me in connection with the processing of any claim for benefits made by the ASSIGNEE therein. A photocopy of this document shall be as binding as an original signature page.

IN WITNESS WHEREOF the undersigned ASSIGNOR and ASSIGNEE have hereunto set their hands-

Date:_____

Patient's Signature (ASSIGNOR):_____ Authorized ASSIGNEE:_____

Patient's Name (please print):_____

AUTO ACCIDENTS

* I authorize the release of PIP/Med payments to Spinal Health and Rehab.
* I authorize Spinal Health and Rehab the right to obtain my Declaration Page of my Auto Policy.

_____ _____

Patient Name (please print) Patient/Guardian Signature

SPINAL HEALTH & REHAB

Electronic Health Records Intake Form

In compliance with Medicare requirements for the government EHR incentive program

First Name:_____ **Last Name:**_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Referred By:_____ **Primary Care Provider:**_____

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication, Vitamin, or Supplement Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ **Date:**_____

For office use only

Height:_____ **Weight:**_____ **Blood Pressure:**_____/_____

SPINAL HEALTH & REHAB
of punta gorda

324 Cross St
Punta Gorda, FL 33950
Phone: (941) 205-2180
Fax: (941) 205-2181

ADDITIONAL INFORMATION REQUESTED

SURGERIES:

MEDICATIONS:

ALLERGIES: