ADVANCED
CHIROPRACTIC CLINIC

Consent to Treatment: Authorization to Release Information and Statement of Financial Responsibility

Revised 5/31/2023

Patient Name:_____ **Date:**_____

Advanced Chiropractic Clinic appreciates the confidence you have shown in choosing us to provide for your rehabilitative needs. The service you have elected to participate in implies a financial responsibility on your part. This responsibility obligates you to ensure payment in full of your fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for the payment of your bill.

As per State and Federal legislation, Advanced Chiropractic Clinic has a single fee schedule that applies to our commercial patients.

We have adopted the following financial policies in an effort to maintain compliance with various State and Federal regulations, managed care, preferred provider agreements, and self pay discounts, as well as billing and coding guidelines:

Please initial each line:

_____ You are responsible for payment of any co-payment at the time of service and for any deductible/coinsurance as determined by your contract with your insurance carrier.

_____ Many insurance companies have additional stipulations that may affect your coverage.

_____ **You are responsible for any amount not covered by your insurer. If your insurance carrier denies any part of your claim, or if you and your physician elect to continue therapy past your approved period, you will be responsible for your account balance in full.**

_____ We are committed to providing excellent care. Research is clear that patients who receive physical therapy modalities such as stretching, muscle work and flexion/distraction have superior outcomes. Insurance companies are trying to increase their own profit by denying patients care. This means your insurance may determine that the physical therapy codes we bill are your responsibility. We have chosen to continue to provide what we know you need instead of allowing insurance to dictate your care. Should your insurance company shift responsibility of the physical therapy codes to you, they are your responsibility to pay. In the event that happens, it may be more cost effective for you to elect to pay our 'time of service self pay fee'. Thank you for allowing us to provide you with the highest level of care.

_____ If your account is not paid in full and is referred to a collection agency, any fees incurred in collecting on your unpaid balance will be your responsibility. For your convenience, we accept cash, checks, and most major credit cards. Payment is expected at the time of service.

_____ Self pay Discount: Patients with no insurance or are underinsured, patients choosing not to use their insurance, and patients who have an insurance plan we do not participate with, we provide a self pay discount.

_____ Payments can be made at the office or by calling our billing office at 303-841-2524.

I have read the above policy regarding my financial responsibility to Advanced Chiropractic Clinic for providing care to the above named patient or me. I certify that the information provided is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Advanced Chiropractic Clinic. I agree to pay Advanced Chiropractic Clinic the full and entire amount of all bills incurred by me or the above named patient and, if applicable, any amount due after payment has been made by my insurance carrier.

Advanced Chiropractic Bills under Advanced Injury Solutions with its own fee schedule for Workers Comp and Auto patients.

Workers Compensation: I certify that the information provided is, to the best of my knowledge, true and accurate. I understand that my place of employment has the right to call and verify appointments and to ask for any information regarding treatment for my workers compensation claim without my authorized consent.

Auto Insurance: I certify that I am providing my/or my family's personal auto insurance information and not third-party insurance (vehicular insurance of someone besides myself), regardless of who is at fault for the accident. I understand that I will be responsible for any amount charged over the MedPay benefit my insurance provides. I will work with both my insurance carrier and AIS to understand what my benefit limitations are.

Signature:_____ (relationship to patient: self — guardian — other: _____) **Date:**_____
Patient Name:_____ **Date:**_____

I acknowledge that the Patients Rights and Responsibilities and Notice for Federal Civil Rights is posted at the location in which I am receiving treatment and that I have read and understand the notice. I further acknowledge that I have the right to request a copy of the notice and one will be provided to me.

Signature:_____ (relationship to patient: self — guardian — other: _____) **Date:**_____

Refund Policy

Advanced Chiropractic Clinic will refund any money due after the patient has been discharged from care. If ACC is billing insurance, we will refund money once we have heard back from and received all payments due by the insurance. For all other patients, the refund will appear as a credit on their account until the credit is exhausted OR the patient has been discharged from care. ACC has up to 45 days to issue the refund once we are aware that a refund is due.

Signature:_____ (relationship to patient: self — guardian — other: _____) **Date:**_____

HIPAA

I consent to the use or disclosure of my protected health information by Chiropractor/Acupuncturist/Massage/Physical Therapy for the purpose of analyzing, diagnosing, or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Chiropractor/Acupuncturist/Massage/Physical Therapy. I understand that analysis, diagnosis, or treatment of me by Chiropractor/Acupuncturist/Massage/Physical Therapy may be conditioned upon my consent as evidenced by my signature below. I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or health care restriction that I request, the restriction is binding on Chiropractor/Acupuncturist/Massage/Physical Therapy . I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractor/Acupuncturist/Massage/Physical Therapy has taken action in reliance on this consent.

My 'protected health information' means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a healthcare clearinghouse. This protected health information relates to my past, present, or future physical or mental health condition and identifies me or there is a reasonable basis to believe the information may identify me. I have been provided with a copy of the Patient's Rights and Responsibilities and understand that I have a right to review the Patient's Rights and Responsibilities prior to signing this document. The Patient's Rights and Responsibilities describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Chiropractor/Acupuncturist. Chiropractor/Acupuncturist reserves the right to change the Patient's Rights and Responsibilities that are described in the Patient's Rights and Responsibilities. I may obtain a revised notice by calling Advanced Chiropractic Clinic and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

I have read, or had read to me, the above consent. I have also had an opportunity to ask questions about its consent, and by signing below I agree to the above names procedures. I also authorize the provider and or managed care organization to release any information required to process insurance claims on my behalf. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided. I intend this consent form to cover the entire course of my treatment for my present condition and for any future conditions for which I seek treatment. I also authorize the provider and or managed care organization to release any information required to process insurance claims on my behalf and authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company. I understand the above information and guarantee this form was completed correctly to the best of my knowledge.

Signature:_____ (relationship to patient: self — guardian — other: _____) **Date:**_____

ACC utilizes an automated system to send emails and/or text messages that deliver information about our office including appointment availability, specials, and important updates about the clinic. Your consent to receive such emails and/or text messages is not a condition of any purchase of a service or product.
I/We have read this disclosure and agree that the Provider, and/or their representative, may contact me/us as described above.
Signature:_____(relationship to patient: self — guardian — other: _____) **Date:**_____

Patient Name:_____ **Date:**_____

BILLING DISCLOSURES TO INDIVIDUALS INVOLVED IN PATIENT'S CARE

There may be times when it is necessary for an individual directly involved in your care to call the office to inquire about your personal health information or billing information. Please take a few moments to complete this section

I authorize Advanced Chiropractic Clinic to disclose my health information that is directly related to my current treatment at Advanced Chiropractic Clinic to the individual(s) listed below for purposes of their role in my treatment or payment for the health services that I have received.

Such persons involved in your care may include: spouse, children, blood relatives, roommates, boyfriends/girlfriends, domestic partners, neighbors and colleagues.

Name	Relationship

I do not wish to have my health information disclosed to the individual(s) named below:

Name	Relationship

We are committed to providing exceptional patient experiences. If you have questions or concerns about your billing, please contact our office at 303-841-2524. Thank you.

There are more signatures needed on the following pages

Patient Name:_____ **Date:**_____

No Show and Late Fee Policy

24 Hour Notice Required

Scheduled appointments are not suggested times, but rather time the provider has dedicated to provide the highest quality of care for each patient.

We at **Advanced Chiropractic Clinic** understand that sometimes you need to cancel or reschedule your appointment and that there are emergencies. You can cancel appointments by calling or texting us at 303-841-2524.

As a courtesy, an appointment reminder text/email is sent to you 48-hours prior to your scheduled appointment. **However, it is the responsibility of the patient to arrive for their appointment on time.**

Please Initial each line.

_____ We **require** 24-hour notice (or day before) to cancel your chiropractic/acupuncture/massage/physical therapy appointment.

_____ We **request** 48-hour notice to cancel your massage appointment due to the length of the appointment.

_____ **If you are more than 10 minutes late for chiropractic and acupuncture appointments and more than 15 minutes late for massage or physical therapy, you will be asked to reschedule your appointment and pay the $50 late fee.**

_____ If you have more than one appointment scheduled on a day, there is a $50 charge for each appointment (i.e. $50 for a missed chiropractic appointment and $50 for a missed acupuncture appointment on the same day.)

This fee is **not covered by insurance**, **including auto, workers compensation and VA insurances**, and must be paid prior to your next appointment. Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients.

It is at the discretion of Advanced Chiropractic Clinic as to when to waive or apply the no show/same day cancellation fee. We understand that sometimes life happens that may prevent you from coming to your dedicated appointment time.

Signature:_____ (relationship to patient: self — guardian — other: _____) **Date:**_____

Patient Name:_____ **Date:**_____

CONSENT OF TREATMENT

CHIROPRACTIC

In this document, 'I' and 'my' refer to me, the patient, and 'Chiropractor' refers to Advanced Chiropractic Clinic and/or Dr. Rebecca LaMaack Schwartz and/or Dr. Ben Lockie and/or Dr. Anthony Paolucci and/or Dr. Lauren Cheslog and/or any other licensed doctor of chiropractic who now or in the future treat me while employed by, or working, or associated with, or serving as 'back-up' for the above named persons.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, muscle work or myofascial release, on me or the patient names below, for whom I am legally responsible by Chiropractor. I have had an opportunity to discuss with Chiropractor and /or other office or clinic persons the nature and purpose of chiropractic adjustments and other procedures. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on Chiropractor to exercise judgment during the course of the procedure which Chiropractor feels at the time, based upon the facts then known to him or her, is in my best interest.

Chiropractic treatment involves the science, philosophy, and art of locating and correcting spinal segmental dysfunction oriented toward improvement of spinal function relative to range of motion, muscular, and neurological aspects. There has been no promise, implied or otherwise of a cure for any symptom, disease, or condition as a result of treatment in this clinic. I understand that a Chiropractor will use his or her hands or a mechanical device upon my body to adjust a joint, which may cause an audible 'pop'. It is my intention to rely on the Chiropractor to exercise professional judgment during the course of any procedures, which he or she feels at the time are in my best interest. Neither the practice of chiropractic or medicine is an exact science, but relies upon information related by the patient, information gathered during examination, and Chiropractor's interpretation thereof, as well as the Chiropractor's judgment and expertise in working with like cases.

ACUPUNCTURE

This disclosure statement is in compliance with the state of Colorado Department of Regulatory Agencies, Colorado Statute Title 12 Article 29.5. All rules and regulations set forth by the Department of Health are strictly adhered to including proper cleaning, sterilization and sanitation of equipment and office.

Education and Experience

Our acupuncturists have completed their Masters of Traditional Chinese Medicine degree from the Colorado School for Traditional Chinese Medicine. The four-year program consists of 3,000 hours of education and 1000 hours of clinical practice. The training includes acupuncture, internal medicine, moxibustion, tuina, cupping, Chinese nutrition, auriculotherapy, and energetic exercise. Our acupuncturists have received their board certification from the National Certification Commission for Acupuncture and Oriental Medicine and are licensed through the state of Colorado. They have received their Clean Needle Technique certification. This clinic complies with the rules and regulations set forth by the Colorado Department of Health and Environment, including the use of single-use, disposable, factory-sterilized needles.

Informed Consent:

I hereby request and consent to the performance of acupuncture and Traditional Chinese Medicine procedures by acupuncturists employed by Advanced Chiropractic Clinic. I have been informed that acupuncture is a safe method of treatment but that it may have side effects including pain, bruising, and numbness at the site of needle, discomfort, and dizziness. Extremely rare risks include nerve damage, organ puncture, possibility of miscarriage, burns from moxibustion or heating lamps, and infection. Other side effects

and risks may occur. If I suspect I am pregnant I will immediately inform the Acupuncturist. I understand that there are no guarantees regarding the improvement of my condition. I understand there may be limitations to the care provided and that, in my best interest, I may be referred to another acupuncture practitioner or other healthcare provider who may be more qualified to treat

Patient Name:_____ **Date:**_____

my condition. I do not expect the Acupuncturist to explain or anticipate all risks or complications. I permit the Acupuncturist to determine and/or alter the course of treatment which is based upon the known facts. I understand that I have the right to accept or reject treatment at any time. I have read and understand the above consent. Also, I have had the opportunity to ask questions regarding this consent. By signing below, I am agreeing to all terms and conditions stipulated by this document. I intend this form to cover the entire course of treatment for my condition and for any future condition (s) for which I seek treatment.

Massage

I understand that the massage therapist is providing massage therapy services within their scope of practice as defined by the Colorado Office of Massage Therapy. I consent for my therapist to treat me with massage therapy for the above noted purposes such as assessments, examinations, and techniques which may be recommended by my therapist.

We offer CBD and essential oils as add-ons to your massage. Some individuals may have allergies or sensitivities to certain oils or their components. Hot Stones and cupping have the small risk of causing burns due to the process used. Please discuss any allergies, sensitivities, or other concerns you have about any optional add-ons before asking the therapist to use them.

Physical Therapy

Physical Therapy involves the use of many different types of physical evaluation and treatment. We use a variety of procedures and modalities to help us to try and improve your function. As with all forms of medical treatment, there are benefits and risks involved with physical therapy.

Since the physical responses to a specific treatment can vary widely from person to person, it is not always possible to accurately predict your responses to certain therapy modalities or procedures. We are not able to guarantee precisely what your reactions to a particular treatment might be, nor can we guarantee that our treatment will help the condition you are seeking treatment for. There is also a risk that your treatment may cause pain or injury, or may aggravate previously existing conditions.

You have the right to ask your physical therapist what type of treatment he or she is planning based on your history, diagnosis, symptoms and testing results. You may also discuss with your therapist what the potential risks and benefits of a specific treatment might be. You have the right to decline any portion of your treatment at any time or during your treatment session.

Therapeutic exercises are an integral part of most physical therapy treatment plans. Exercise has inherent physical risks associated with it. If you have any questions regarding the type of exercise you are performing and any specific risks associated with your exercises, your therapist will be glad to answer them.

I am aware of my diagnosis and voluntarily consent to have Advanced Chiropractic Clinic, through its appropriate personnel, provide evaluation and/or treatment as prescribed by my physician and/or recommended by my therapist. I understand the practice of chiropractic, acupuncture, and massage therapy is not an exact science, and I acknowledge that no guarantees have been given to me regarding the successful completion of the results of the treatment provided. I understand that the treatment I receive from Advanced Chiropractic Clinic is limited to chiropractic, acupuncture, massage therapy, and/or physical therapy services and that I shall seek treatment from other medical professionals for all other issues I may experience. I understand that I have the right to ask questions at any time during the course of my care.

Signature:_____ (relationship to patient: self — guardian — other: _____) **Date:**_____