Mandatory Disclosure, Informed Consent, HIPAA and Cancellation Policy

ADVANCED CHIROPRACTIC CLINIC
11020 S. Pikes Peak Dr.
Suite 110
Parker, CO 80138
303-841-2524

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, her preceptor 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 judgement 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 ofo a cure for any symptom, disease, or condition as a result of treatment in this clinic. I understand that Chiropractor will use his or her hands or a mechanical device upon my body to adjust a joint, which may cause an audible 'pop' or 'click'. It is my intention to rely on Chiropractor to exercise professional judgement 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 Chiropractors judgement 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:

Alex Grover, L.Ac M.T.O.M. earned his Master of Acupuncture and Oriental Medicine degree from Emperor's College in Santa Monica, CA. This five-year program consists of 2,240 classroom hours and 970 hours of clinical training. Alex's training includes adjunctive therapies including moxibustion, tui na, acupressure, cupping, auriculotherapy, nutrition and lifestyle recommendations. Alex is certified by the National Certification Commission for Acupuncture and Oriental Medicine and the California Acupuncture Board. He is a registered acupuncturist in California and Colorado and has been practicing since 2015. Alex has special training in Korean four-needle technique and Five Element Acupuncture. None of these licenses, certificates, or registrations has ever been suspended or revoked.

Informed Consent:

I hereby consent to treatment with the use of acupuncture, Traditional Chinese Medicine (TCM), and injection procedures by Alex Grover, L.Ac. M.T.O.M.. I have been informed that acupuncture, TCM, and injections are safe methods of treatment but that they may have side effects including pain, bruising, and numbness at the site of the needle, discomfort and dizziness. Extremely rare risks include nerve damage, organ puncture, posssibility 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 Alex Grover, L.Ac M.T.O.M.. 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 my condition. I do not expect Alex Grover, L.Ac M.T.O.M. to explain or anticipate all risks or complications. I permit Alex Grover, L.Ac M.T.O.M. to determine and/or alter the course of treatment which is based on 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.

Patients' Rights:

**In a professional relationship, sexual intimacy is never appropriate and should be reported to the Director of the Division of Registration in the Department of Regulatory Agencies (DORA).

**The patient is entitled to received information about the methods of therapy, the techniques used, and the duration of the therapy (if known).

**The patient may seek a second opinion from another healthcare professional or may terminate therapy at any time.

**The practice of acupuncture is regulated by the Colorado Department of Regulatory Agencies (DORA). The Director's address and telephone number is:

Director, Division of Registrations
1560 Broadway, Suite 1350
Denver, CO 80202
(303) 894-7800

_____ _____

Print Patient's or Guardian's Name Date

_____ _____

Patient's or Guardian's Signature Date

HIPAA

I consent to the use or disclosure of my protected health information by Chiropractor/Acupuncturist 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. I understand that analysis, diagnosis, or treatment of me by Chiropractor/Acupuncturist 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. I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractor/Acupuncturist 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 Notice of Privacy Practices of Chiropractor/Acupuncturist and understand that I have a right to review the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices 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 PrivacyPractices that are described in the Notice of Privacy Practices. I may obtain a revised notice by calling the Chiropractor/Acupuncturist 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_____ Date_____

Signature Acknowledging the Receipt of HIPAA Policy

Print_____

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OFFICE POLICY ON INSURANCE

This clinic will try to assist the patient whenever possible:

1) Submitting to insurance is a courtesy and may be withdrawn at any time.
2) The patient must stay current with their co-pay or percentage of responsibility (i.e. Insurance pays 80% of the bill and the patient pays the remaining 20%).
3) If the patient discontinues care for any reason, any balance due is payable in full immediately; regardless of any claims submitted.
4) All deductible amounts must be paid prior to insurance submittal.
5) When our clinic receives an insurance check, if there is any balance due at that time the patient must pay the remaining balance within 30 days.
6) Patients from out of state are responsible for all fees incurred in our office at the time of service. Our office will supply you with the forms needed for you to submit to your insurance.
7) The office does not promise that an insurance company will pay, nor does this clinic promise that an insurance company will or should pay the fees as charged.
8) The clinic will not enter into a dispute with an insurance company over reimbursement of the amount of the reimbursement. This is the patient's obligation.
9) The fees charged at this clinic might be higher or lower than at other clinics. A schedule of services and fees may be secured from the receptionist.
10) 24 Hour Cancellation & "No Show" Fee Policy Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Advanced Chiropractic Clinic, reserves the right to **charge a fee of $50.00 for each missed appointment for <u>each</u> appointment type** (i.e chiropractor, massage, and acupuncture) that, absent a compelling reason, are not cancelled with a 24-hour advance notice. **"No Show" fees will be billed to the patient.**

I AGREE TO PAY $50.00 FOR ANY MISSED APPOINTMENT,
IF I DON'T GIVE AT LEAST A 24 HOUR CANCELLATION NOTICE.

Print Patient Name_____ Date_____

Signature_____ Date_____
(Signature of Patient or Guardian)