SOUND BODY
Health & Chiropractic

INSURANCE INFORMATION

Do you have insurance coverage? _____ Yes _____No
Insurance Company Name: _____
Responsible Party (person responsible for insurance/bill): _____
Relationship of the responsible party (insured) to you: _____ Self _____Spouse _____Other:_____
Insured's Date of Birth: _____ ID # _____ Group # _____
Provider ONLY Phone # _____Type: _____ HMO _____PPO _____EPA ____EPO ____KAISER

Were you involved in an Auto Accident? ____ Yes ____No
Work Injury? ____ Yes _____No Date of Injury: _____
Auto/WC Insurance Company: _____ Auto/WC Claim # _____
Adjuster Name: _____ Adjuster Phone #: _____

Insurance is a method of receiving reimbursement for services rendered by a provider. Having insurance is not a substitute for payment. Many insurance companies have fixed allowances or percentage rates set by your contract with them. It is your responsibility to pay at the time of service any deductible, co-pay, or co-insurance fees not paid for by your insurance company. If you are being seen for a work or auto related injury it is your responsibility to provide our office with any and all information necessary to receive payment or it will become your financial responsibility to pay for services rendered.

ASSIGNMENT OF BENEFITS & CONSENT TO TREATMENT

I Hereby give permission to the doctor to release any information requested by my insurance company, physicians, or other health care providers acquired in the course of my examination and treatment. I hereby authorize and direct my insurance benefits to be paid directly to the doctor. I am financially responsible for non-covered services and I understand that all services are to be paid in full at the time of service. I hereby give permission to the doctor and/or therapist to administer treatment and perform such general procedures as he/she may deem necessary in the diagnosis and/or treatment of my condition. I fully understand that this consent will remain in effect until revoked in writing. I have and I do understand and agree to the above statements.

_____ _____
Patient Signature **Date**

_____ _____
Signature of responsible party (if patient is a minor) **Date**

12792 W. Alameda Pkwy, Ste. E, Lakewood, CO 80228 Phone: 303-953-5200 Fax: 3035937454

Sound Body Health & Chiropractic

Cancellation / Missed Appointment Policy

In order to serve you better, please provide us with at least 24 hours notice if you will be unable to attend your appointment. This advance notice allows us to provide other patients awaiting an appointment the opportunity to receive care.

If you miss an appointment without providing at least 24 hours notice you will be responsible for the following charges:

- **$25 - No show chiropractic appointment**
- **$25 – No show functional medicine appointment**
- **$35 – No show half hour massage appointment**
- **$65 – No show 1 hour massage appointment**

I, (print your name or name of responsible party here) _____agree to pay the appropriate cancellation fee if I fail to notify Chiropractic & Wellness Specialists at least 24 hours in advance of my appointment.

_____ _____

Patient Signature **Date**

_____ _____

Signature of responsible party (if patient is a minor) **Date**

Sound Body Health & Chiropractic

Notice of Privacy Policy

INTRODUCTION

We are committed to treating and using protected health information about you responsibly. The Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. We are required by law to maintain the confidentiality of your individually identifiable health information. We are also required by the Health Insurance Portability and Accountability Act (HIPAA) to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your Protected Health Information (PHI).

We realize that these laws are complicated, but we must provide you with the following important information.:

- **How we may use and disclose your PHI**
- **Your privacy rights regarding your PHI**
- **Our obligation concerning the use and disclosure of your PHI**

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice has posted a copy of our current notice in our office in a visible location at all times. You will be given the opportunity to review and/or receive a copy of the Privacy Practices upon request.

By signing this form below, I acknowledge the above terms of the Privacy Policies

_____ _____

Patient Signature **Date**

_____ _____

Printed Name **Date**

_____ _____

Signature of responsible party (if patient if a minor) **Date**

Sound Body Health & Chiropractic
Financial Policy Agreement

Thank you for choosing Dr. Peter Halvorson, DC, as your Chiropractic healthcare provider. We are committed to giving you the best care possible, and we want you to completely understand our financial policies. There are always ongoing changes in the healthcare industry, and these changes may affect you in the services that are covered by your insurance carrier, or in services that are determined to be due and payable directly by you. The following is a statement of our Financial Policy, which we require you to read and sign **prior to** any treatment.

- ❑ Payment is due at time if service unless arrangements have been made in advance. Your financial responsibility to us will be your cash fee (if you do not have insurance coverage), co-payments and the amount your insurance company deems your responsibility such as deductibles and coinsurance, and denials for services not covered under your policy. We accept cash, checks, and credit cards. Please note if paying by check, all dishonored or returned checks are subject to a $30 charge to your account.
- ❑ Keep in mind that your insurance policy is basically a contract between you and your insurance company and as the patient, you are ultimately responsible for the payment for services rendered. As a service to you, we file your insurance claim and the insurance company usually pays us directly. Please bring your insurance card and personal identification to each appointment.
- ❑ Due to the multiplicity of insurance plans, we are unable to know each carrier's reimbursements and what procedures apply to your deductible and what does not. It is your responsibility to contact your insurance carrier directly for your specific benefits.
- ❑ Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered" you will be responsible for the complete charge. Payment is due upon the receipt from our office.
- ❑ The billing department will file your Medicare Claims. Medicare supplemental insurance is billed as a courtesy to you. If no payment is received from your supplemental insurance within sixty days of filing, the balance becomes your responsibility, and we will bill you.
- ❑ Only after exhausting our internal attempts for payment, we will send a delinquent account to our collection agency or small claims court. Should this happen, you will be responsible for all costs incurred in collecting the account. You will be required to pay your account in full before scheduling another appointment if your account is in collections.
- ❑ In the instance of prepayment for service, should care be discontinued at any point, a prorated refund will be issued. If financial arrangements were made, and care is discontinued at any time, payment is still due for services rendered.

I have read and understand the above FINANCIAL POLICY AGREEMENT, and I agree to be bound by its terms.

_____ _____

Name of Patient (PLEASE PRINT) **Date**

_____ _____

Signature of Patient (or responsible party if minor) **Date**

Sound Body Health & Chiropractic
Informed Consent to Treatment

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: physical examination, tests, physiotherapy, physical medicine, etc. on me by the doctor of chiropractic and/or other assistants and/or licensed practitioners.

Chiropractic examination and therapeutic procedures are considered safe and effective methods of care. Occasionally, however, complications may arise. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. These complications may include, but are not limited to, soreness, inflammation, soft tissue injury, dizziness, headaches, and temporary transient worsening of symptoms. More serious complications are extremely rare, but do occur. Some types of manipulation of the neck have been associated with injuries to arteries in the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate all risks and complications. However, I wish to rely upon the doctor to exercise the best judgement during the course of the procedure(s), which the doctor feels at the time, based upon the facts then known, that are in my best interest. I also understand that I will be given an explanation of the procedures to be rendered, any alternatives available to me, relative risks for specific procedures, and any questions I have will be welcomed, appreciated, and answered to the best of the physician's ability.

I will receive the majority of my care under the supervision of the attending physician licensed to provide chiropractic care. However, there may be times that it will be clinically warranted to have the therapy provided by the attending massage therapist, limited to the scope of their license to provide care. By my signature, I give permission for my attending physician and the licensed massage therapist to discuss my care as needed in order to provide complete clinical care.

I understand that I play an important role in my own health care. Just as a patient can choose to discontinue care at any time, the doctor reserves the right to terminate a doctor-patient relationship for non-compliance and/or other reasons that affect the doctor-patient relationship. I also understand that there is no guarantee or warranty for specific care results.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____

Patient Signature Date

_____ _____

Guardian Signature (if patient is a minor) Date