springfield wellnesscenter

Last Name:

1000 S Durkin Dr.
Springfield IL 62704
(217) 726-0422
www.WellnessSpringfield.com

Welcome to The Springfield Wellness Center

Welcome to our office! Rest assured that you will be provided the most appropriate and professional healthcare possible. Our most important goal is the constant improvement and maintenance of your health. Before we get started with your examination procedures, which will determine if we can help you, we want you to understand what we do and why we are going to do it.

When a person seeks our care and when we accept a patient for such care, it is essential that they are both working towards the same goals. The goal of our office is to allow your body to function at its highest potential, free from interference and stress that causes dysfunction, disease, and eventually symptoms and sickness. Most importantly, you must understand that our care is not a substitute for medical treatment of any kind, in anyway, or for any reason. The medical approach treats symptoms and diagnoses conditions and diseases. Patients usually go to their medical doctors to get rid of whatever symptoms or conditions are bothering them. This is symptom, sickness and disease care and is necessary in emergency situations. Our approach recognizes that you get symptoms for a reason, attempts to find the cause of the symptoms, and addresses the function of the whole body. This is how we define healthcare; focusing on the optimum function of the individual, and it is what we do it in our office.

We provide various services in our office including Chiropractic care, massage therapy, exercise therapy and nutritional services. The purpose of Chiropractic care is to restore and maintain the integrity of the spine, spinal cord and its nerve roots. Vital nerve pathways are housed within and protected by the bones of the spine call vertebrae. Misalignments of those vertebrae, which interfere with transmission of normal nerve impulses, are called SUBLUXATIONS. Subluxations are the most common cause of nerve system interference (pinched nerve) and cause dysfunction to the tissue and organs that these nerves supply. With appropriate Chiropractic care, these subluxations can be reduced and corrected, which will restore normal nerve function. A properly functioning nerve system is the foundation to good health.

The information we get from you on the following pages is important. For this reason, please fill out our history forms completely and to the best of your ability so that we can quickly get you on the road to health. We look forward to a healthy relationship with you and your family.

I, _____, have read the above, understand it.

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Last Name:

Date: _____ Social Security #_____

Name: _____
Last First M.I

Address_____

E-mail (please provide for communication purposes) _____

Cell Phone:_____ Home Phone: _____

Sex: _____Male _____ Female Age:_____ Birthdate:_____

___Married ____Separated ____Widowed ____Divorced ____Single ____Partnered for ___Yrs ____Minor

Preferred method of communication: (Check one) Email___ Phone ___

Patient Employer/School _____

Address:_____

Phone: _____ Occupation:_____

Spouse's Name:_____ Phone:_____

Birthdate:_____ Spouse's Employer: _____

Emergency Contact:_____ Relationship:_____ Phone_____

ACCIDENT INFORMATION: Is condition due to an accident? Yes____ No____ Date of Accident _____
Type of Accident: Auto ____ Work ____ Home____ Other ____

INSURANCE INFORMATION:

Who is responsible for this account? _____ Relationship to patient:_____

Insurance Co:_____ ID#_____

Subscriber Name _____ Birthdate:_____

ASSIGNMENT AND RELEASE: I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Drs. Robert Calcaterra and Michael Jones, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named doctor may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____

Please print name of above signature Relationship to Patient

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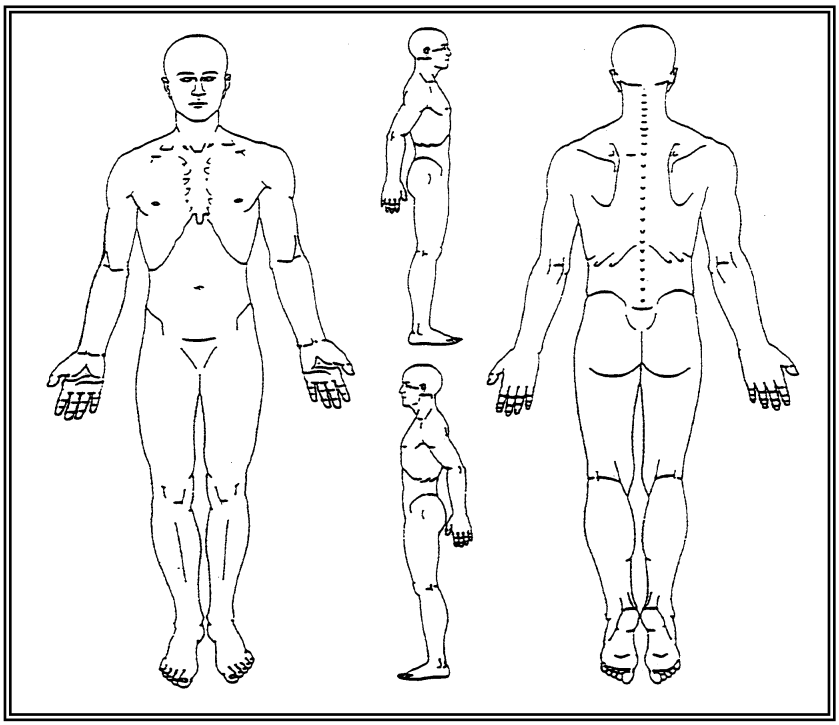
Please let us know who we can thank for referring you to our office: _____

Please indicate the main reason you are seeing us today: _____

If you are seeing us for a pain related issue, use the symbols to show what type of pain you feel on the diagram.

XXXXXXXXX	/ / / / / / / / / /	o o o o o o o o o	S S S S S	- - - - - - - -
DULL/ACHY	**SHARP/STABBING**	**NUMBNESS/TINGLING**	**STIFF/TIGHT**	**BURNING**



Using the pain scale below, circle the pain level you experience when this problem is at its very worst:

0 = No Pain. No Discomfort
1 = Minimal Discomfort. Minor stiffness or tightness.
2 = Discomfort. Stiff, tight, sore. Muscle fatigue.
3 = Minimal Pain. More than just sore. Uncomfortable.
4 = Mild Pain. Noticeable pain but tolerable.
5 = Moderate Pain. Aggravating. Still allows movement.
6 = Strong Pain. Quite aggravating. Movement slightly limited.
7 = Very Strong Pain. Very aggravating. Movement definitely limited.
8 = Very, Very Strong Pain. Extremely aggravating. Movement very limited.
9 = Severe Pain. Brings tears. Almost impossible to move.
10 = Excruciating Pain. Agony. Unbearable. Cannot move. ER.

Do you have any other health conditions, regardless of whether you think it's related to your spine:

_____

_____

_____

Is there any radiating pain into the arms or legs? _____ Is there any numbness or tingling? _____

How long have you been suffering with this problem, has it been more than a month or two? _____

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When was the first time you EVER recall having a problem in this area? _____

How often are you suffering with this problem? (Please indicate for each of the body area of concern)

Constant (75 – 100% of the time) _____Frequent (50 – 75% of the time)_____

Occasional (25 – 50% of the time) _____ Intermittent (0 – 25% of the time) _____

Every trauma is recorded in the spine. Please give a brief description of any significant injuries or accidents over the course of your life (slips, falls, injuries, car accidents) , whether or not you think they are related to your spine:

_____

_____

_____

Did you go to the hospital for any of these injuries? _____

Did you get any X-rays for any of these injuries? _____

Did you get checked by a Chiropractor after any of these injuries?_____

List any MD's or Chiropractors you've already seen for your current problem:

_____

What do you do most of the day in your job postures, positions and repetitive movements:_____

_____

What tests have you already had for this problem? ☐X-rays ☐MRI ☐C.T. Scan ☐Myelogram ☐EMG/NCV
☐None ☐Other _____

What have you already tried for this problem? ☐Anti-inflammatory ☐Pain Meds ☐Muscle Relaxers
☐Injections ☐Physical Therapy ☐Chiropractic ☐Massage ☐Exercise ☐Other _____

What makes your problem <u>worse</u>? ☐Sitting ☐Standing ☐Changing Position ☐Walking ☐Bending ☐Lifting ☐Twisting
☐Reaching ☐Driving ☐Sleeping ☐Sneeze/Cough ☐Computer Work ☐Telephone ☐Going From Sit to Stand
☐Other_____

What activity does this problem prevent you from doing, either partially or totally, that you would really like to be able to do again? _____

What area of your life has this problem affected the most? ☐Family ☐Relationships ☐Work ☐Exercise ☐Recreation

_____

On a scale of 1 to 10, with 10 being the highest, rate your level of commitment to get rid of this problem: _____

Please list any concerns you may have about getting this problem corrected such as time or transportation:

_____

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Medical Symptoms Questionnaire

Patient Name_____ Date _____

Rate each of the following symptoms based upon your typical health profile for:
□ Past 30 days

Point Scale
0 - Never or almost never have the symptom
1 - Occasionally have it, effect is not severe
2 - Occasionally have it, effect is severe
3 - Frequently have it, effect is not severe
4 - Frequently have it, effect is severe

HEAD

_____ Headaches
_____ Faintness
_____ Dizziness
_____ Insomnia

Total _____

EYES

_____ Watery or Itchy Eyes
_____ Swollen, Reddened or Sticky Eyelids
_____ Bags or Dark Circles Under Eyes
_____ Blurred or Tunnel Vision
(does not include near or far-sighted)

Total _____

EARS

_____ Itchy Ears
_____ Earaches, Ear Infections
_____ Drainage from Ear
_____ Ringing in Ears, Hearing Loss

Total _____

NOSE

_____ Stuffy Nose
_____ Sinus Problems
_____ Hay Fever
_____ Sneezing Attacks
_____ Excessive Mucus Formation

Total _____

MOUTH / THROAT

_____ Chronic Coughing
_____ Gagging, Frequent Need to Clear Throat
_____ Sore Throat, Hoarseness, Loss of Voice
_____ Swollen or Discolored Tongue, Gums, or Lips
_____ Canker Sores

Total _____

SKIN

_____ Acne
_____ Hives, Rashes, Dry Skin
_____ Hair Loss
_____ Flushing, Hot Flashes
_____ Excessive Sweating

Total _____

HEART

_____ Irregular or Skipped Heartbeat
_____ Rapid or Pounding Heartbeat
_____ Chest Pain

Total _____

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LUNGS

_____ Chest Congestion
_____ Asthma, Bronchitis
_____ Shortness of Breath
_____ Difficulty Breathing

Total _____

DIGESTIVE TRACT

_____ Nausea, Vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated Feeling
_____ Belching, Passing Gas
_____ Heartburn
_____ Intestinal/Stomach Pain

Total _____

JOINTS / MUSCLE

_____ Pain or Aches in Joints
_____ Arthritis
_____ Stiffness or Limitation of Movement
_____ Pain or Aches in Muscles
_____ Feeling of Weakness or Tiredness

Total _____

WEIGHT

_____ Binge Eating/Drinking
_____ Craving Certain Foods
_____ Excessive Weight
_____ Compulsive Eating
_____ Water Retention
_____ Underweight

Total _____

ENERGY / ACTIVITY

_____ Fatigue, Sluggishness
_____ Apathy, Lethargy
_____ Hyperactivity
_____ Restlessness

Total _____

MIND

_____ Poor Memory
_____ Confusion, Poor Comprehension
_____ Poor Concentration
_____ Poor Physical Condition
_____ Difficulty in Making Decisions
_____ Stuttering or Stammering
_____ Slurred Speech
_____ Learning Disabilities

Total _____

EMOTIONS

_____ Mood Swings
_____ Anxiety, Fear, Nervousness
_____ Anger, Irritability, Aggressiveness
_____ Depression

Total _____

OTHER

_____ Frequent Illness
_____ Frequent or Urgent Urination
_____ Genital Itch or Discharge

Total _____

GRAND TOTAL _____

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PERSONAL HEALTH GOALS

☐Improve Nutrition/Eating Habits	☐Lower Cholesterol	☐Get off Medications
☐Weight Loss/Fat Loss	☐Lower Blood Pressure	☐Improved Sleep
☐Increase Lean Muscle Mass	☐Start Exercising	☐Improved Energy
☐Increase Bone Density	☐Look Better	☐Improved Posture
☐Reduce Stress	☐Feel Better	☐Improved Outlook/Happiness

On a scale of 1 to 10 with 1=Poor and 10=Excellent, please rate how well you think you are doing in the following categories:

Exercise_____ Sleep _____ Diet _____ Stress Level _____ Water Intake _____ Energy Level_____

Do you take: Omega 3 (Fish Oil)? Yes No Vitamin D3? Yes No Probiotics? Yes No

Who is your Family Physician or Primary Doctor that monitors you? _____

When was the last time you had blood work done? _____

PAST MEDICAL HISTORY

Please list any significant conditions that you've been diagnosed with or been treated for over the course of your life: _____

Please list any surgeries you have had over the course of your life: _____

MEDICATIONS & ALLERGIES

Are you allergic to any medications? ☐Yes ☐No **If yes, please list:** _____

List any medications you are taking: _____

FAMILY HISTORY

Mother: ☐Living ☐Deceased List any medical problems: _____

Father: ☐Living ☐Deceased List any medical problems: _____

List any problems common in your family: ☐Cancer ☐Diabetes ☐Heart disease ☐High blood pressure ☐Stroke ☐Arthritis ☐Scoliosis ☐Thyroid disease ☐Osteoporosis ☐ Other _____

SOCIAL HISTORY

Do you have any children? ☐Yes ☐No If yes, how many? _____

Do you drink alcohol? ☐Yes ☐No If yes, how much & how often? _____

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

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Protecting Your Confidential Health Information is Important to Us

Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Dear Patient:

This is not meant to alarm you! It is our desire to communicate to you that we are taking the Federal (HIPAA- Health Insurance Portability and Accountability Act) laws written to protect the confidentiality of your health information seriously. We do not ever want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside our office.

Why a privacy policy?

The most significant variable that has motivated the Federal government to legally enforce the importance of the privacy of health information is the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we use to ensure the protection of your health information everywhere it is used.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal laws regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your HEALTH INFORMATION only for the purposes of providing our treatment, obtaining payment and conducting health care operations. Your health information will not be used for other purposes unless we have asked for and been voluntarily given your written permission.

HOW YOUR HEALTH INFORMATION MAY BE USED:

To Provide Treatment

We will use your HEALTH INFORMATION within our office to provide you with the best health care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between physician assistant, nurse, physician and business office staff. In addition, we may share your health information with referring physicians, clinical and pathology laboratories, pharmacies or other health care personnel providing your treatment.

To Obtain Payment

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunity use clinical situations experienced by patients receiving care at our office. As a result health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointment agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routing processes of certification, licensing or credentialing activities.

In Patient Reminders

Because we believe regular care is very important to your general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interests to you or your family. These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best preventive and curative care modern medicine can provide. They may include postcards, letters, telephone reminders or email reminders (unless you tell us that you do not want to receive these reminders).

Abuse or Neglect

We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement.

Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or to national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

For Law Enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask permission first. In the case of an emergency, where you are unable to tell us what you want, we will use our very best judgment when sharing your health information only when it will be important to those participating I providing your care.

To Coroners, Funeral Directors and Medication Examiners

We may be required by law to provide information to coroners, funeral directors and medial examiners for the purposes of determining a cause of death and preparing for a funeral.

Medical Research

Advancing medical knowledge often involves learning from the careful study of the medical histories of prior patients. Formal review and study of health histories as a part of a research study will happen only under the ethical guidance, requirements and approval, and of an Institutional Review Board.

Authorization to Use of Disclose Health Information

Other than is stated above or where Federal State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

Patient Rights

This new law is careful to describe that you have the following rights related to your health information

Restrictions - You have the right to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our patients.

Confidential Communications - You have the right to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members preset or through mailed communications that are sealed. We will make every effort to honor your reasonable requests for confidential communications.

Inspect and Copy Your Health Information - You have the right to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend Your Health Information - You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change. Your request may be denied if the health information record in question was not created by our office, is not part of our records, or if the records containing your health information are determined to be accurate and complete.

Documentation of Health Information - You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment, or health operations. Our documentation procedures will enable us to provide information on health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.

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Request a Paper Copy of this Notice - You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you. We are required by law to maintain the privacy of your health information and to provide to you and your representative the Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice.

You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.

Patient Acknowledgement: *Thank you very much for taking time to review how we are using your health information. If you have any questions, please let us know. If not, please acknowledge your receipt of our policy by signing below. Thank you!*

_____

Patient name: PLEASE PRINT

_____ _____

Patient Signature

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Last Name:

INFORMED CONSENT

CHIROPRACTIC
It is important to acknowledge the difference between the health care specialties of chiropractic, osteopathy and medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from chiropractic health care services.

ANALYSIS
A doctor of chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VSC). When such VSS or VSC complexes are found, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body.

DIAGNOSIS
Although doctors of chiropractic are experts in chiropractic diagnosis, the VSS and VSC, they are not internal medical specialists. Every chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concern as to the nature of his/her total condition. Your doctor of chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

INFORMED CONSENT FOR CHIROPRACTIC CARE
A patient, in coming to the doctor of chiropractic, gives the doctor permission and authority to care for the patient in accordance with chiropractic tests, diagnosis and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment, or health care, if he/she is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the doctor of chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The doctor of chiropractic proves a specialized, non-duplicating health service. The doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

RESULTS
The purpose of chiropractic services is to promote natural health through the reduction of the VSS or VSC. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the chiropractic procedures. Sometimes the response is phenomenal. In most cases there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through chiropractic. In turn, we must admit that conditions which do not respond to chiropractic care may come under the control or be helped through medical science. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have made great strides in alleviating pain and controlling disease.

TO THE PATIENT
Please discuss any questions or problems with the doctor **before** signing the statement of policy.

I have read and understand the foregoing

_____ _____
Date Signature

X-Ray Consent

I hereby give my consent to Silveri Chiropractic Inc. and its representatives to take X-rays as deemed appropriate by the examining Doctor of Chiropractic. I also declare that to the best of my knowledge, I am not pregnant. I have read and understood all the above information.

_____ _____
Patient Signature Date

springfield wellnesscenter

Last Name:

ASSIGNMENT OF BENEFITS – AUTHORIZATION & LEIN

I the assignee, being the patient or legal guardian for said minor, listed below, do hereby irrevocably authorize, direct, assign, and give a lien to The Springfield Wellness Center Springfield, hereinafter referred to as the "Facility" against any and all insurance benefits, proceeds of any settlement, judgment or verdict which may be paid to the undersigned as a result of the injuries or illness for which I have been treated by the Facility all sums of money due to them for any and all services rendered to me or minor by whom I am responsible for by reason of accident, illness and by any and all reason of any other bills that are due or may become due and to withhold such sums from any health and accident, workers compensation and/or including all insurance or third party benefits. Assignee agrees that this Facility and staff may deliver medical records, consultations, depositions, and/or court appearances which must be paid in full in advance and authorizes this Facility to release any information pertinent to said health care to any insurance company, adjustor, attorney or legal service bureau to facilitate collections under the terms of this document. Assignee grants the Facility a full power of attorney to endorse and/or sign my name on any and all checks for payments of any indebtedness owed this office and assignee.

INSURANCE BENEFITS – CREDIT POLICIES – PAYMENT TERMS & CONDITIONS

1. As a courtesy, the Facility will obtain a verification of applicable insurance benefits as they are quoted to us but some third party payers mis-quote benefits, coverage and liability. Our Facility and staff are not responsible for what a third party payer and/or representative may tell us. Any contractual, written, verbal or other obligations or arrangements between you and an attorney, insurance company, liable third party payer are between you and said person.
2. I understand that if the insurance carrier pays differently than what was quoted and this difference results in a balance on my account, the balance will be my responsibility.
3. I understand that the Facility will do their best to notify me when reaching my policy limits, whether it is a visit limit or a specific dollar amount. Should I exceed this limit and it results in a balance on my account, the balance will be my responsibility.
4. I understand that many insurance carriers have a filing deadline for claims. Should my insurance carrier change and I fail to notify the Facility within the valid filing period, the resulting charges will be my responsibility.
5. I understand that an insurance carrier has up to two years from the date they process a claim to audit their records. If such audit results in an overpayment on my claim that is recalled by the Facility, I will be responsible for this amount. The insurance carrier may or may not notify me of this recall.
6. Co-pays, deductibles and all non-covered service charges are due the day the service is rendered.
7. Patients are responsible for charges on all service(s) and/or product(s) which may exceed the maximum allowable and/or when a third party and/or insurance carrier does not reimburse this Facility enough to meet our cost of service.
8. All account balances, including automobile and work injury claims must be paid in full within 90 days of treatment. Patients are fully responsible for all money owed to this office and such payment is not contingent on any settlement, claim, judgment, or verdict by which they may eventually recover said fee and it is also regardless of any attorney liens or pending settlements. If a third party payer fails to pay said balance in full within 90 days, the patient must pay the balance in full. Assignee is fully responsible for money owed to this Facility for any and all treatment, products, and services rendered to the patient or minor shown below.

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9. A service charge is computed by a "periodic rate" of 1 ½% per month- 18% per annum and is added to all balances owed 60+ days. Any balance past due 90 days or more will be submitted to an attorney and/or agency for legal collection for which the undersigned agrees to be 100% responsible for all monthly service charges, costs related to but not limited to all collected related expenses, attorney fees, court and filing fees. Returned checks, debit and credit charges made payable to this Facility for insufficient funds, stop payment or other reasons of non-payment will be assessed a $20.00 charge.
10. Please ask any questions you may have regarding your bill and/or fees to our insurance and billing department. We do not want any misunderstandings regarding your bill, obligation to pay or terms of when payment is due. For your convenience, we accept most major debit and credit cards.
11. The maximum balance that will be carried by the office is $200.00. If your account exceeds $200.00, you will be asked to pay at the time of service.
12. I understand that I will be responsible for costs of collection in the amount of 30% of the balance should this account be turned over to my collection agency because of nonpayment

PATIENT CONSENT & SIGNATURE

By my signature below, I acknowledge that I have read or had read to me and have received a photocopy upon request of this document including the Health Care Privacy Notice, Facility Terms & Conditions, credit policies, and Informed Consent and fully understand and have had all of my questions answered to my satisfaction. A photocopy of this document shall be considered as effective and valid as an original.

_____ _____

Print Name of Patient Witness Signature

_____ _____

Signature Date

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Last Name:

BIA PREPARATION

- No alcohol within 24 hours
- No exercise for 4 hours before
- Avoid food or caffeine for 4 hours before
- Consume 2-4 glasses of water within 2 hours of test