COSH CHIROPRACTIC

Cosh Chiropractic Care
2001 Pine Street
Redding CA 96001
530-244-1185

LEGAL DOCUMENTATION

PLEASE CAREFULLY REVIEW THE FOLLOWING

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

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HIPAA NOTICE OF PRIVACY PRACTICE & AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION:

Protecting your privacy and personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to define situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on your disclosures. You may inspect and receive copies of your records within 30 days with a request. In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff. I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights and privacy regarding my protected health information. I understand that this information can and will be used to: conduct, plan, and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly, obtain payment from third party payers, and conduct normal healthcare operations. By signing, you are stating that you have read and understand our Notice of Privacy Practices. A more complete description can be requested. You also understand that, if requested in writing, you may restrict how your personal information is used and disclosed.

Authorization to Use or Disclose Protected Heath Information

I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions.

In addition, I hereby authorize this office and any of its employees to use or disclose my Patient Health Information, billing information, and any other applicable information to the following person(s):

NAME: _____ DATE OF BIRTH: _____

NAME: _____ DATE OF BIRTH: _____

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INFORMED CONSENT

As with any healthcare procedure there are certain complications which may arise during chiropractic manipulation and therapy. Doctors of Chiropractic are required to advise patients that there are risks associated with such treatment. In particular you should note:

1.) Some patients may experience some stiffness or soreness following the first few days of treatment.
2.) Some types of manipulation have been associated with injuries to the arteries of the neck leading or contributing to serious complications including stroke. This occurrence is exceptionally rare and remote. However, you are being informed of the possibility regardless of the extreme remote chance.
3.) I will make every effort to screen for any contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.
4.) Other complications may include fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns.

The probabilities of these complications are rare and generally result from some underlying weakness of the bone or tissue which I check for during the history, examination, and x-ray (when warranted).

I acknowledge I have had the opportunity to discuss the associated risks as well as the nature and purpose of treatment with my chiropractor. I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal manipulation. I intend this consent to apply to all my present and future chiropractic care.
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Terms of Acceptance

In order to provide for the most effective healing environment, most effective application of chiropractic procedures and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic. To that end, we ask that you acknowledge the following points regarding chiropractic care and the services that are offered through this clinic:

A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.

B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from the normal spinal structures and configurations that interfere with normal nerve processes.

C. The chiropractic adjustment process, as defined in the "law of this jurisdiction" involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments.

D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If, during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider of specialist, according to the initial indications of the need,

E. Chiropractic does not seek to replace or compete with your medical, dental or other type(s) of health professionals. They retain responsibility for the care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.

F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health through chiropractic.

G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration or cost, in what we work to maintain as a supporting, open environment.
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FINANCIAL AGREEMENT & BILLING AKNOWLEDGMENT

We would like to take a moment to welcome you to our office and assure you that you will receive the very best of care available for your condition. We offer several methods of payment for your chiropractic care and you pay choose the plan which best suits your needs. In order to familiarize you with the financial policy of this office we would like to explain how your medical bills will be handled.

** NO SHOW FEE $30 ** CANCELLATION / NO SHOW POLICY:

In order to provide the best possible care to our patients, it is important that you keep your scheduled appointments. We offer text reminders to patients who choose to participate. Occasionally the system goes down, so reminders are NOT an excuse for nonpayment of our NO SHOW FEE. Failure to cancel an appointment for therapy without 24-hour notice will result in NO SHOW FEE OF $30.

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SELF-PAY: The self-pay plan means that all fees will be paid when rendered. Fees are discounted for payment at the time of service. Our office provides exceptional care to our **Cash and CarePackage patients**. Our rates are the lowest in town. If you would like to have **maintenance care** at our office we would be happy to offer this at our generous cash rates.

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INSURANCE BILLING

Many insurance policies do cover chiropractic care but this office makes no representation that yours does. Insurance policies may vary greatly in terms of deductible and percentage of coverage for chiropractic care. Because of the variance from one insurance policy to another, we require that you, the patient, be personally responsible for the payment of your deductibles, as well as any unpaid balances in this office. The initial amount collected MAY CHANGE once your insurance processes your claim. We will do our best to verify your insurance coverage, and will bill your insurance in a timely manner as a courtesy to you.

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MEDICAL NECESSITY AND SEPARATE SERVICES:

Having insurance coverage available is NOT a guarantee of payment. We recommend that you contact your health plan to confirm coverage for Chiropractic and Physical Medicine services prior to signing this form. **Insurance does NOT cover any maintenance therapy**. Even if your insurance states that you treatment is available under your plan, treatment is covered based on Medical Necessity and that is shown through improvement in your condition. Insurance companies have clinical reviewers who have established a certain level of care per condition. Once it is deemed maintenance care, the insurance may deny further services for the treated condition. Please speak with our staff or contact your insurance for further explanation.

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SEPARATE SERVICES

While your insurance does allow for certain treatments, the treatment must be prescribed by your doctor. The doctor will examine you and discuss with you your options for a treatment plan. Insurance plans do NOT allow some therapies to be provided on the same day to the same area *(or adjacent areas)* where chiropractic spinal manipulation *(spinal adjustment)* was performed. If the doctor recommends therapy, you may be required to schedule separate appointments. The other option is a discounted cash massage that may not be billed to insurance. Please speak with our staff or contact your insurance for further explanation.

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AUTHORIZATIONS

Some insurance plans require prior authorization for treatment. It is important that you complete all required forms to the best of your ability. Failure to adequately complete forms and follow the treatment plan provided may result in denied claims leaving you responsible for payment. Your insurance may consider your treatment **maintenance care** and may deny your authorization. In order for your insurance to authorize treatment, it is required that patients complete the recommended forms provided at your appointment.

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Assignment of Benefits:

By signing this form you are authorizing payment of medical benefits will be made directly to this office. If your insurance carrier sends payment to you for services incurred in this office, you agree to send or bring those payments to this office upon receipt. However if you pay for your visits in full the assignment will not be reported by this provider and any payment will be sent directly to you.

Voluntary Termination of Care

If you suspend or terminate your care at any time, your portion of all charges for professional services is immediately due and payable to this office. All services rendered by this office are charged directly to you, and you, ultimately will be personally responsible for payment regardless of your insurance coverage.

We hope this answers any questions you might have concerning the financial policy of this office. Once again we welcome your to our office, and will be glad to answer any further questions that you might have.

I understand that a paper copy of this document is available upon request. I have read and agree to the above.

I understand that a paper copy of this document is available upon request. By signing, I am contesting that I have read and agree to the above.

SIGNATURE: _____ DATE: _____