CONSENT FOR TREATMENT

NATURE OF ADJUSTMENTS: I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and a cure may not be available. I understand, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment; temporary treatment symptoms may include, but are not limited to, muscle spasms, aggravation and/or increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect either chiropractor, Dr. Montgomery or Dr. Towner, to be able to anticipate and explain all risks and complications, and I will allow him to exercise his expertise in my care. **NATURE OF ADDITIONAL TREATMENTS:** I understand supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. The treatments can include but are not limited to soft-tissue techniques such as Active Release Technique and GRASTON Technique, and other therapy techniques. Additional rehabilitative techniques such as Corrective Exercise and Activities of Daily Living instruction may be suggested and prescribed. Like all other health modalities, results are not guaranteed and there is no guarantee of cure. **RELEASE FOR ADDITIONAL TREATMENT:** I further understand that the treating chiropractor will exercise his medical judgment to implement the necessary plan for my care. This may include referring me to a specialist for additional review, tests and/or intervention if my symptoms do not improve or worsen. **CONSENT TO TREAT:** I hereby request and consent to the performance of chiropractic procedures and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the treating chiropractor and his support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, whether signatories to this form or not. I have had an opportunity to discuss with the treating chiropractor and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and additional treatments. 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 any treatment listed above as considered necessary by Dr. Montgomery or Dr. Towner. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek additional treatment. **RIGHT TO REFUSE SERVICE**: I understand that the treating chiropractor *reserves the right* to refuse services if patient is considered "Non-Compliant" to RST policies or the doctor's prescribed care. If treatments are refused, I further understand that the reason will be documented and a referral may be made if circumstance allows. **I authorize Dr. Dakota Montgomery, D.C., C.E.S. or Dr. Seth Towner, D.C. to diagnose and treat my present complaint, as well as any additional relevant complaints addressed in the future unless I release myself or am released from his care.**

INITIAL _____

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT for RST

HIPAA PRIVACY POLICY: *This notice of Privacy Practices describes how Redding Sports Therapy & Chiropractic may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information.*

DEFINITION OF PHI: "Protected Health Information", PHI, is information about you that may identify and/or relates to your past, present or future physical or mental health or condition(s) and any related health care services. PHI also includes your demographics, personal information such as mailing and physical address, financial records, work and family information.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION: Your PHI may be used and disclosed by any physician(s) you have established care with for the following purposes: providing health care services, health care financial preparations, bills, and repayment, to support the operation of the physician's practice, and any other use required or subpoenaed by law.

DISCLOSURES FOR HEALTH TREATMENT: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you, or a health care facility that provides care for you.

DISCLOSURES FOR HEALTHCARE OPERATIONS: We may use or disclose, as-needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training, licensing, communications with EHR tech support, and conducting or arranging for other business. For example, we may disclose your PHI to medical professionals, including certified therapist and health-orient independent contractors that see patients/at our office. In addition, we may use a sign-in sheet or electronic tablet at the registration desk where you will be asked to sign under your name. We may also call you by name in the waiting room when your doctor is ready to see you. We may use or disclose your PHI to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: Public Health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation, criminal activity, military and National Security, Workers' Compensation, inmate status, and required uses and disclosures. By law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent. We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objection to this form, speak with our office manager in person or by phone.
We reserve the right to change the terms of this notice and will inform you of any changes.

DISCLOSERS FOR PROVIDER COMPENSATION: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for treatment may require that your relevant protected health information be disclosed to the health plan to obtain approval for the treatment. We will provide PHI as necessary to our billing service, Chiro-HELP, to obtain reimbursement for your visits.

PHI ELECTRONIC TRANSMISSION: Please be advised that we will use Electronic Health Records (EHR) programs to transmit your information. EHR programs include Office Ally, Practice Mate, Practice Fusion and ChiroTouch. Your PHI may also be transmitted over password-protected electronic communications such as e-mail or instant messenger programs sponsored by Yahoo, Google and Hotmail. We strive to keep your information protected through regular electronic security updates and password encryptions.

PATIENT RIGHTS REGARDING PROTECTED HEALTH INFORMATION: You have the right to inspect and copy your PHI. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to protected health information. You have the right to request a restriction of your protected health information. You may ask us not to use or disclose any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If the physician believes that it is in your best interest to permit use and disclosure of your PHI, your protected health information will not be restricted. You then have the right to use another healthcare professional. You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically. You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.
You may revoke this authorization at any time, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization. You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by notifying our office of any breach in privacy as specified in this contract. We will not retaliate against you for filing a complaint. We would like to hear and address your complaint and amend any possible exposure of your PHI through situations not accounted for in this contract. Please direct your complaints to the office manager and allow at least 3 business days for a response. This notice was published and becomes effective on January 2015.

___ I authorize Dr. Montgomery, Dr. Towner, RST staff members, and RST billing service representatives, to leave messages on my home / cell / work number(s).

___ I authorize Dr. Montgomery, Dr. Towner and his staff members to discuss my protected health information (PHI) with the following people:

NAME _____ RELATIONSHIP _____ PHONE_____

NAME _____ RELATIONSHIP _____ PHONE_____

BILLING POLICIES

You are financially responsible for all bills associated with your visit. ***All patient-responsibility balances are due at time of service.*** INSURANCE POLICIES: ***All co-pays and payments toward your deductible (if applicable) are due at the time of service.*** RST seeks to be as accurate as possible when collecting your insurance rate at the time of service, however there may be a small credit or balance once insurance processes fully. **If claims are not paid by the insurance provider within 60 days after billing, the remaining balance will become the patient's responsibility. NO EXCEPTIONS.** You are solely responsible for all balances your insurance carrier states you owe. Anything billed to your insurance is subject to contracted provider rates IF they accept the billed procedure code(s). It is NOT Redding Sports Therapy's policy to retro-bill your insurance for previous visits paid on cash rates.

INITIAL_____

AFLAC - I plan on retro-billing an AFLAC policy (circle one) YES / NO

NON-COVERED SERVICES AGREEMENT (NSA)

I have been informed that services are billed as chiropractic (not as physical therapy). I have been informed that the services recommended or provided during my treatment may not be fully covered or may be denied by my insurance company or health plan under the terms of my benefit plan with (check one):

Blue Cross Blue Shield United Health Care Cigna Aetna Other (List)_____ None/Pvt Pay

I would like to be treated by Dr. Montgomery or Dr. Towner and agree to pay for the services performed by or under the direction of the doctor if my insurance denies any service based on (a) medical necessity, (b) may not be performed on the same area as a chiropractic adjustment or (c) a non-covered service.

I understand and agree to be responsible to self-pay for the following services in the case of the insurance denying them:

Procedure	**Charge**
E-stim/Ultrasound/Decom Units	$22-80/ per unit
Corrective Exercise	$35/ per session
Myofascial Release Technique(s)	$32/ per session
Chiropractic Adjustments (Spinal or Ext)	$32-60/ per session
Evaluations	$92/ per exam

Please note you may have additional coverage options for these services through your medical insurance benefits. RST & Montgomery Chiropractic (RST) recommends that you contact your health plan to inquire regarding your CHIROPRACTIC coverage for these services.
I acknowledge that I have reviewed my coverage options and that I have been informed in advance what portion of my care I will have to pay for, including services as described above, and agree to make financial arrangements with RST in the event of non-coverage. This agreement is valid for the duration of care with the treating chiropractor unless it is revised and resigned.
BILLING ASSIGNMENT – please check one of the following:

____BILL MY INSURANCE. I understand I am fully responsible for the chiropractic contracted rates of my insurance and any service they do not cover. I understand I may be required to pay at time of service if I have a deductible, a co-pay, and/or services not supported by my insurance.

____DO NOT BILL INSURANCE. I would like Private-Pay services. I understand I will be required to pay in full at time of service.

EMERGENCY CONTACT

In the case of emergency or to update contact information, please list the person RST may contact:

NAME _____ RELATIONSHIP _____ PHONE_____

****A $25 CHARGE WILL BE APPLIED TO PATIENT ACCOUNTS, per occurrence, if patient does not give 24-hour notice *prior to* cancellation or rescheduling.** Three (3) "No-Show" appointments make patient status "Non-Compliant" and patient will be discharged from all future care at RST. Patient accounts are to remain current and fees paid in full for continuance of care**. RST Appointment TEXT/EMAIL ALERTS is a courtesy. There are occasions when the text/email alerts do not send out due to unforeseen technical difficulties. Please be sure to note your upcoming scheduled appointments.**

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RE-EXAMS – I understand that Re-Exams will be conducted approximately every 90 days, or less, when there are new clinical findings, failure to respond to interventions or a modification to a plan of care. Re-Exams help the doctors to refocus care or sometimes at discharge to document goals achieved or not achieved or instructions given.

HEALTH INSURANCE PLANS THAT DO NOT PAY (not applicable to Private Pay (CASH) patients)
I understand that the health insurance that I seek to use for payment of services is **NOT** a *Medi-Cal plan*, *Covered California plan*, *a Partnership Health Plan*, *a Keenan Health Care plan*, *a Shasta Regional Health Care plan*, *or a Prime Health Care plan*.

WORKER'S COMPENSATION/AUTO ACCIDENT/PERSONAL INJURY
I can attest that the services I am requesting from Redding Sports Therapy & Montgomery Chiropractic is **NOT** to treat any injury/issue related to an open case of **Workers Compensation, Auto Accident or Personal Injury**. I understand that I cannot use any or all treatments from Redding Sports Therapy & Montgomery Chiropractic for any future legal claim.

INITIAL_____

INSURANCE BENEFITS & PAYMENTS (not applicable to Private Pay (CASH) patients)
I understand that RST will run a courtesy eligibility check, however it is not a guarantee of coverage. ***I understand that it is ultimately my responsibility to call my insurance provider to confirm my chiropractic insurance benefits.*** I understand that *before* insurance billing is fully processed, any payment I make towards my account at RST is **ONLY an estimated amount owed.**

I understand that *after* billing is fully processed, **IF** my insurance provider denies payment for any part of their estimated portion, **it is ultimately my responsibility to pay the remaining balance, in full, within 10 days of receiving a billing statement** to Redding Sports Therapy & Montgomery Chiropractic. **If my account becomes overdue, a late-fee (10% of the balance owed) will be applied every month until my account is paid-in-full.**

I understand that I am responsible for any dispute that I may have with my insurance provider, regarding denial of payment. **Insurance disputes will not be handled by Redding Sports Therapy & Montgomery Chiropractic on my behalf.**

INITIAL_____

SIGNATURE ASSIGNMENT
I agree that I have read RST's Consent for Treatment, HIPAA Policy, Billing Policies, & Non-Covered Services Agreement. I understand all that is stated above regarding Workers Compensation, Auto Accidents, Personal Injury claims, Insurance plans not accepted, Insurance benefits & Payments. By signing below, I formally accept the terms within these documents.

SIGNATURE _____ **DATE**_____

PRINT NAME_____

***IF PATIENT IS MINOR*. Above signee legal guardian or power of attorney. Name of signee** _____