PINNACLE CHIROPRACTIC HEALTH AND WELLNESS CENTER

PINNACLE MAXRECOVERY CRYOTHERAPY

Please assist us by *clearly* and *correctly* completing the information in the outlined areas. ***Do not write in the shaded areas.*** Please give your insurance card(s) to the receptionist for copying.

PATIENT INFORMATION

FIRST MIDDLE INITIAL LAST	EMAIL ADDRESS	GENDER M☐ F☐
STREET ADDRESS	MARITAL STATUS ☐SIN ☐MAR ☐SEP ☐DIV ☐WID	EMPLOYMENT ☐FULL ☐PART ☐RETD ☐UNEM / STUDENT? ☐FULL ☐PART ☐NO
CITY STATE ZIP	SOCIAL SECURITY # - -	BIRTHDATE - - / SPOUSE'S NAME
HOME PHONE - - / CELL PHONE - - / WORK PHONE - -	EMPLOYER'S NAME	JOB DESCRIPTION

BILLING INFORMATION (leave blank if same as above)

FIRST NAME MIDDLE INITIAL LAST NAME	MAIL CODE	ACCT. TYPE
STREET ADDRESS	CITY STATE ZIP	

PRIMARY COVERAGE

POLICY HOLDER NAME	RELATIONSHIP TO INSURED ☐SELF ☐SPOUSE ☐SON ☐DAUGHTER ☐OTHER ☐DISABLE
PRIMARY INSURANCE CO. NAME & ADDRESS	POLICY # / GROUP #
EMPLOYER	SOCIAL SECURITY # - - / BIRTHDAY - -

PRIMARY CARE PROVIDER

DOCTOR'S NAME or PRACTICE NAME	CITY / STATE

AUTHORIZATION

THE ABOVE SUBSCRIBER HEREBY AUTHORIZES HIS/HER INSURANCE COMPANY TO ISSUE INDEMNITY CHECKS TO THE ABOVE LISTED MEDICAL PROVIDER FOR SERVICES PROVIDED.

I request that payment of authorized benefits be made on my behalf. I fully assign the benefits payable for services to the physician or organization furnishing the services and authorize such physician OR organization to submit a claim to my insurance carrier OR Medicare for payment. Any auto insurance policy or lawyer is directed to pay the medical provider directly and shall not pay me with expectation that I pay for the services with proceeds from a claim. I authorize any holder of medical or other information about me to release to insurance carriers OR the Health Care Financing Administration and its agents OR the Social Security Administration or its intermediaries OR any agency, group or person(s) necessary to secure payment any information needed for this of related Medicare claim. * For and in consideration of services rendered and to be rendered by the above listed medical provider, I hereby guarantee payment of all charges incurred for this account. * The patient or his/her representative recognizing the need for health care, consents to the above listed medical provider rendering services as ordered by the physicians, including medical or surgical treatment, laboratory procedures, x-ray examinations or other services rendered under the general and specific instructions of the physicians. * I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct.

I agree that any testimonial provided in a public forum (Facebook, Google, Yelp, etc.) or any video/picture filmed on-site at Pinnacle Chiropractic with my permission may be used for further marketing purposes which may include, but not limited to, brochures, advertisements, online videos and posts. By signing below, no consent is given for reproduction or distribution of verbal testimonials.

DATE PATIENT SIGNATURE (Parent/Guardian if minor)

X-RAY/PREGNANCY INFORMATION

I give permission to Pinnacle Chiropractic to take plain x-ray films for diagnostic purposes if needed only. I also acknowledge that I am not pregnant.

This form must be signed be a parent or guardian if the patient is a minor.

Print Patient Name: _____

Patient/Guardian Signature: _____ **Date:** _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare options.

Patient Signature: _____ **Date:** _____

General Health Information

Current Prescription Medicine

Name: _____ Dosage: _____
Name: _____ Dosage: _____
Name: _____ Dosage: _____
Name: _____ Dosage: _____

Allergies To Medication

Name: _____
Name: _____
Name: _____
Name: _____

Smoking Status (circle one): Never Former Some Day Everyday

Blood Pressure (circle one or fill in): High Low _____/_____

Height: _____ **Weight:** _____

HEALTH CARE AUTHORIZATION FORM

Patient's Name: _____

Patient's SS # : _____ Date of Birth: _____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES PINNACLE CHIROPRACTIC TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

Specific Authorizations

Initial:

_____ I give permission to Pinnacle Chiropractic to use my address, phone number and clinical records to contact me with birthday cards, holiday related cards and information about treatment alternatives or other health related information.

(OPEN ROOM AUTHORIZATION – OPTIONAL)

_____ I give Pinnacle Chiropractic permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor any time in private, the doctor will provide a room for these conversations.

_____ By signing this form, you are giving Pinnacle Chiropractic permission to use and disclose your protected health information in accordance with the directives listed above.

Expiration

The authorization shall expire on the following date: _____

Right to Revoke Authorization

You have the right to revoke this authorization, in writing, at any time. However, your written request to revoke this is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this authorization by mailing or hand delivering a written notice to the Privacy Official of Pinnacle Chiropractic. The written notice must contain the following information:

- Name, Social Security and Date of Birth
- A clear statement of your intent to revoke this authorization
- The date of your request
- Your signature

The revocation is not effective until it is received by the Privacy Official.

This authorization is requested by Pinnacle Chiropractic for its own use/disclosure of PHI. (Minimum necessary standards apply)

You have the right to refuse to sign this authorization. If you refuse to sign this authorization, Pinnacle Chiropractic will not refuse to provide treatment.

A copy of the signed authorization will be provided to you on request.

_____ _____

Print Name of Patient **Signature of Patient**

_____ _____

Date **Signature of Personal Representative**

Description of Representative's Authority to Act for Patient:

_____

_____

_____

TREATMENT INFORMATION

The primary treatment used by doctors of chiropractic is spinal manipulation or adjustments. We will use this procedure in your treatment program. We also have other modalities including Physical Therapy, Cryotherapy, Hyperbaric Therapy, Infrared Sauna Therapy and Regenerative Medicine. Any of the additional therapies mentioned will have separate informed consent provided prior to treatment.

The Nature of Chiropractic Manipulation

We will use our hands to manipulate or loosen and reposition the joints of your spine. Often with this procedure, you will hear a popping noise associated with the loosening of repositioning.

The Material Risks Inherent to Chiropractic Manipulation

As with any health care procedure, there are certain complications that may arise from chiropractic manipulation. These complications may include aggravation of degenerative or injured spinal discs, rib fractures, ligament sprains, muscle strains, nerve injury or spinal cord compression. Manipulation of the neck has been associated with injury to arteries in the neck leading to or contributing to stroke. Local soreness and or stiffness is typical in the early phases of treatment.

Probability of Those Risks Occurring

Fractures are rare occurrences and generally result from underlying bone weaknesses, which we check for during the history, examination and x-rays. The exact incident of stroke is uncertain, but it is generally believed to occur in less than one in one-million treatments. We employ physical tests that are advocated to screen for this risk, but they are generally accepted as being insensitive. All other complications are also generally described as rare.

The Availability and Nature of Other Treatment Options

Other treatment options for your condition may include:

- Over-the-counter medications and rest
- Medical care which may include anti-inflammatory drugs, muscle relaxants and pain medications.
- Surgery

Material Risks Inherent to Your Other Treatment Options

The common analgesics and anti-inflammatory drugs have been shown to cause damage to the stomach and intestines and possible to the kidneys. Approximately one in 150 patients taking anti-inflammatory drugs for extended time periods requires hospitalization for stomach ulceration. There are about 16,500 deaths in the U.S. each year from these complications, which is more common than deaths from either Hodgkin's disease or cervical cancer. The risks are similar for both prescription anti-inflammatory as well as over-the-counter medications.

Spine surgery may be a consideration for some cases. However, it is reserved for those cases where extensive conservative treatment has been tried. Spine surgery is associated with a minor complication rate of between nine per 100 and 15 per 100 cases depending on the area of the spine involved. More serious complications of the nervous system may occur in one per 400 cases, and death has been reported in approximately one per 1,500. While spinal manipulation is associated with complications in a small number of cases, it has a complication rate of several thousand times less than other typical treatment options.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

I have read _____ or have had read to me _____ the above explanation of chiropractic manipulation or adjustment and related treatment. I have discussed it with the doctor and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interests to undergo the treatment recommended. Having been informed of the risks, I hereby give consent to that treatment. Dated: _____

_____ Printed Name - Patient

_____ Printed Name - Witness

_____ Signature - Patient

_____ Signature - Witness

_____ Signature of Guardian (if a minor)

TREATMENT GOALS AND OPTIONS

Name:

Goals

At Pinnacle Chiropractic Health and Wellness Center, we pride ourselves on having the latest options and technology not only to treat your current symptoms, but also to help you reach all of your health care goals. With that in mind, please list your current top 3 health goals. Getting out of pain is important, but think about what that pain might be limiting you from doing. Perhaps you'd like to be able to exercise more comfortably. Maybe playing with your children or grandchildren is now difficult. Please go beyond the simple statement of, "I want to be in less pain," and write down what you want to do once your pain is better. You can also put goals that you want to accomplish in the future regarding your health.

1._____
_____

2._____
_____

3._____
_____

Additional Treatment Options

We have so many ways to help you reach the above goals. Some you may know about, others you may not. Below is a list of additional services we offer. Please review below, and if you have any interest in any of these services, or if you would like to learn more about them, please check the box and we will explain the service in greater detail.

- ☐ ***Physical Therapy****
- ☐ ***MassageTherapy***
- ☐ ***Non-Surgical Disc Decompression***
- ☐ ***Dry Needling****
- ☐ ***MLS Laser Therapy***
- ☐ ***Whole Body Cryotherapy***
- ☐ ***Localized Joint or Muscle Cryotherapy***
- ☐ ***Hyperbaric Oxygen Therapy***
- ☐ ***Infrared Sauna Therapy***
- ☐ ***Stem Cell Treatment***
- ☐ ***Platelet Rich Plasma Treatment***
- ☐ ***"Shockwave" Therapy***
- ☐ ***Cryosculpting Fat Loss***
- ☐ ***Weight Loss Consultation***
- ☐ ***Nutritional Supplements***
- ☐ ***Cryofacials and Aesthetic Services***
- ☐ ***Normatec Leg Compression***
- ☐ ***3D Printed Custom Orthotics***

**This service may be covered by some insurances*

OFFICE FINANCIAL POLICY EFFECTIVE 2/1/2023

Our policy is to extend you the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces you out of pocket expense and allows you to place your entire family under care. Additionally, for out of pocket expense, we are able to accept cash, check and credit cards. We also offer financing for patients on packages over $400 through a third party.

IF YOU ARE SELF-PAY: All payments are expected in full prior to service or by an authorized payment plan. If services are provided and payment is not made at time of service, you will have up to seven days from the time of service to make payment before account is sent to our collections agency.

IF YOU HAVE INSURANCE: All co-payments, estimated deductible/co-insurance payments and account balances will be due at the time of service OR a credit card must be on file with the office. If your account has a balance of over $50, you will not be seen for any appointment until that balance is paid, unless a payment plan has been arranged. If you are unable to make a payment at time of service, your appointment may be rescheduled. If your account balance remains over $40 after notification of balance and no payment has been made, after 30 days, your account will be sent to our collection agency.

You are considered a cash patient until we verify and accept your insurance coverage. Our fees are considered usual, customary and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area.

If you do not provide us with your most current insurance information and subsequently any charges are denied, you will be responsible for the full charge. We are subject to strict guidelines for timely filing of claims, and unfortunately we cannot know if your insurance changes without you telling us!

If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full for any outstanding balance and authorize us to use your credit card to collect full payment. If payment is made by the insurance company following your personal payment, your account will be credited or you will receive a refund.

If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you regardless of any claim submitted.

CANCELLATION POLICY: Certain procedures are associated with a short notice cancellation fee. Specifically, physical therapy, dry needling, massage and hyperbaric therapy. The reason we do this is because they are longer appointments and a short notice cancellation makes other patients miss out on their ability to use those services. We do not charge a cancellation fee for chiropractic appointments with greater than 60 minutes advance notice. See next page for details. However, massage, physical therapy, dry needling and hyperbaric appointments missed or canceled with less than 24 hours notice will be charged a fee according to the table below:

Massage, 30 min:	***$25 Fee***
Massage, 60 min:	***$40 Fee***
Massage, 90 min:	***$60 Fee***
Physical Therapy:	***$50 Fee***
Dry Needling or Hyperbaric:	***$45 Fee***

***********IMPORTANT!!!!********

If we are able to fill a massage, physical therapy or dry needling appointment at the same level of service, we will not assess the fee, so even if you think it's too late to cancel, please do us the courtesy (and possibly yourself) of calling anyway. Missed appointment fees must be paid within 48 hours or the card on file will be charged.

Patient's Printed Name: _____

Patient's Signature: _____ **Date:** _____

APPOINTMENT POLICY EFFECTIVE FEBRUARY 1, 2023

PLEASE READ CAREFULLY. NO EXCEPTIONS ARE MADE.

NO-CALL/NO-SHOW 3 STRIKES: If you miss a chiropractic appointment without calling at least 60 minutes in advance of the appointment to let us know, this is considered a No Call/No Show (NCNS). If your appointment was first thing in the morning, a message should have been left on the voicemail. After one grace NCNS, a fee of $25 will be assessed for the second violation and the fee must be paid prior to seeing you again. If a third NCNS happens without the fee being paid, you will be dismissed from the practice.

LATE FOR APPPOINTMENT: If you are greater than 15 minutes late for your appointment without prior notice/approval, you will be rescheduled for a later date. Likewise, if you are earlier than 15 minutes for your appointment, without prior notice/approval, you will not be seen any earlier than your appointment time. We ask that you be on time for your appointment so that we can respect everyone's time equally.

MASSAGE, PHYSICAL THERAPY, HYPERBARIC AND DRY NEEDLING: Prior to scheduling any of these options, we must put a credit card on hold OR take payment for the service at the time of scheduling. Fees are applied for missed or canceled appointments with less than 24 hours notice. INSURANCE CANNOT BE BILLED FOR THIS FEE. NO FUTURE APPOINTMENTS WILL BE MADE UNTIL THIS FEE IS PAID. A NCNS three strikes rule will apply, regardless of fees paid. After the third NCNS, you will be dismissed from the practice.

Chiropractic Visit (2nd NCNS): $25 Fee
Massage, 30 min:

Patient's Printed Name: _____
Patient's Signature: _____ **Date:** _____