# Terms of Acceptance

The goal of Curis Functional Health office is to enable patients to gain control of their health. To attain this, we believe communication is the key. There are often topics that are hard to understand and we hope this document(s) will clarify those issues for you. Please read the below and if you have any questions please feel free to ask one of our staff members.

## HIPPA

Federal law requires that we obtain your written acknowledgement of receipt of the Notice of Privacy Practices. I acknowledge that I have received and or been offered the Notice of Privacy Practices. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

## Communications

May we leave messages regarding your personal healthcare information on any answering device, i.e. home answering machines or voicemails? May we contact you via phone or email regarding your care?

Yes [] No []

## Informed Consent:

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at Curis Functional Health, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

## Missed Appointments:

There is a possible fee charged for all appointments that are not canceled **24 BUSINESS HOURS** prior to scheduled visit and for consecutive no show appointments. Please note that for Monday appointments, an early cancellation would need to occur the Friday prior. There is no exception to this policy. In the event of contagious illness, I understand and agree I will not come to the office and will communicate with Curis Functional Health. If I miss or late cancel my scheduled session, the credit card on file will be charged the fee. If the card is declined, payment isn't processed, or the charge is disputed, I consent to waive my confidentiality with regards to attendance and financial matters in order to resolve my financial obligations. We strongly encourage a reschedule if your appointment is going to be missed to avoid the fee.

## Consent to Release:

In the event that Curis Functional Health would need to communicate your healthcare information, to whom may we do so? Consent to Release is valid for one year. Purpose for this consent is for authorization/utilization review, payment billing, coordination or care and or other.

- Spouse: _____
- Children: _____
- Insurance Company: _____
- Attorney: _____
- Other: _____

NO ONE _____ Declined to Consent Date: _____

## Court Action Policy and Fees

Clients are discouraged from having their clinician &/Curis Functional Health, LLC subpoenaed or having to provide records for the purpose of litigation. Clinicians are trained to work with clients from a non-adversarial position, not forensically, and do not have the expertise to appear in court. Forensics is an area of clinical specialization and we're happy to provide recommendations for those outside services.

Even though you are responsible for the testimony fee, it does not mean that the testimony of the clinician will be solely in your favor. S/he can only testify to the facts of the case and her/his professional opinion.

If the clinician is to receive a subpoena, then the attorney or office staff will need to call the office and set up time for the subpoena to be served during office hours. A minimum of 14 days' notice of any court appearance is required so that schedule changes for clients can be made within a reasonable time frame.

Please note if a subpoena is received without a minimum of 14 days' notice there will be an additional $500 express charge.

**Court Action Fees are as follows:**

| | | |
|---|---|---|
| 1. | Correspondence & Letter of Opinion: (billed in 15 min increments) | $200 per hour |
| 2. | Preparation Time: (billed in 15 min increments) | $200 per hour |
| 3. | Phone Calls: (billed in 15 min increments) | $200 per hour |
| 4. | Filing Documents with court | $100 |
| 5. | Minimum charge for court appearance | $1,000 ≤ half day<br>$2,000 for full day |

***Attorney fees:*** I, _____ the client, agree to pay all attorney's fees and costs that are incurred by the clinician &/ Curis Functional Health, LLC as a result of any court action. Reimbursement is due in full at time of appearance.

***Retainer:*** A retainer of $1500 is due within 48 hours of subpoena. The remainder of the cost will be billed at the court appearance and will be due upon receipt the same day.

If the therapist/physician is subpoenaed and the case is reset with less than 72-hour notice prior to the beginning of the day of the scheduled subpoena and or testimony is not given, then the client will be billed $1000. Bills for court related actions are presented to clients on a weekly basis and payment is expected upon receipt. A zero balance will need to be kept at all times.

## Consent to Evaluate and Treat a Minor:

I, _____ being the parent(s) or legal guardian(s) of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care by a Curis Functional Health chiropractor and whomever he or she may designate as assistants to administer examinations and chiropractic care as deemed necessary.

## Acknowledgement

I have read and fully understand the **ALL OF THE ABOVE** consents and agree to the consents.

Printed Name: _____

Signature_____

Date: _____

# Integrated Patient Questionnaire

**Curis Functional Health** is an **Integrated Wellness Center.** What does Integrated mean? It means Doctors of Chiropractic, Mental Health Professionals & Dietitians / Nutritionists all working together to provide a greater spectrum of services. This model allows you the convenience of a multi-disciplinary approach without the headache of juggling multiple doctors at multiple locations on multiple schedules. You shouldn't have to put off dealing with one problem while you deal with another. You deserve quick, concise, expert patient care for all of your needs, and you deserve all of those experts working together to know what each other are doing for you and why.

**HELP US HELP YOU AND THE ONES YOU LOVE**

Here is a list of some of the more common problems that our staff are especially well trained to deal with.

**Please check those that you or your immediate family suffer from:**
**X = you F= family member**

| | | |
|---|---|---|
| | __Neck Pain | __Lower Back Pain |
| | __General Chronic Pain | __Chronic Arthritis |
| | __Fibromyalgia | __Bulging or Herniated Disc |
| | __Neuropathy (Arms or Legs) | __Sciatica |
| | __Knee Pain or Degeneration | __Shoulder Pain or Degeneration |
| | __Rolled Shoulders or "Humpback" | __Trigger Points (Knots or Spasms in your muscles) |
| | __Carpal Tunnel Symptoms | __Headache |
| | __Insomnia, Anxiety, Worry or Panicked | __Trouble Coping after Difficult life changes |
| | __Feeling down, depressed, Apathetic | __Chronic Fatigue or Difficulty sleeping |
| | __Trouble in your relationships<br>__Parenting Problems | __History of Trauma |
| | __Feeling Anxious, Tense, Stressed | __Difficulty Managing Weight |
| | __Emotional Eating/ Overeating | __Diabetes/ Pre Diabetes |
| | __Lack of Exercise, Physically Unfit | __Other Problems that haven't previously responded to treatment? Please List: |

## Credit Card Authorization Policy & Signature Form

This form authorizes Curis Functional Health to keep my credit card on file and manually charge the fee for service to this credit card number in the event that:

**(a)** Payment was not rendered at time of service
**(b)** I am not present to pay for my minor child at the time of service
**(c)** Therapist provides consultation outside of sessions (billed per 15 minutes)
**(d)** I missed my scheduled appointment
**(e)** I cancelled with less than or equal to 24 hours of notice
**(f)** I'm on a therapy payment plan, in which case debits will be made on the agreed upon dates
**(g)** My account has an outstanding balance and has been delinquent for 10 business days

I, the undersigned, have read and agree to the credit card authorization policy.

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Client Signature Printed Name Date

**Card Type: VISA MC AMEX DISC OTHER**

**Card Number: _____**

**Expiration Date: _____**

**3 Digit Code on the back of Card: _____**

**5 Digit Billing Zip Code: _____**

**Name of Credit Card Holder: _____**

**Date: _____**