The Elements of Health *...Natural & Functional Healthcare*

8711 East Pinnacle Peak, Suite F113, Scottsdale, Arizona, USA 85255
phone 480-563-4256 / fax 480-563-4269 / www.theelementsofhealth.com

Welcome to the Elements of Health

Please take a few moments to give us some information about yourself and your lifestyle so that we can serve you more efficiently. *Please **print** all information as clearly as possible. Thank you!*

We really like E-mail correspondence

Home E-mail address:____

Would you like to be placed on our monthly newsletter? _________Yes ________No

(We do not sell or share your email, it is only for communication with this office)

First Name:______________________________Last Name:____

Address:

____

City:______________________________State:____________________________Zip Code:______________

Home Phone: (_____)_________________________Work Phone: (_____)__________________________

Cell Phone: (_____)________________________________

Birth date:_____________________________Age:_______Social Security #:________________________

Name of Spouse:______________________________________

Name(s) of Children____

____

Emergency Contact:____________________Relationship:____________Phone#:___________________

Pets, hobbies, travels, daily routines, diet style, concerns thoughts or comments. Anything to help us get to know you and your lifestyle better. Your lifestyle reflects your health and your health reflects your lifestyle.

____

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____

I heard about your office thru?: ☐ Internet ☐ Newspaper ☐ Person ☐ Other

Name and/or relationship to person?

____

(Patient referrals are important; the person who referred you will receive a complimentary $60.00 visit.)

Financial Policies

There are several types of financial arrangements for care in this office: Cash, Medicare, Personal Injury, and Worker's Compensation. It is important that you read through these policies and understand them so that no misunderstandings arise during our work together.

Payment Methods

Payment is expected as services are rendered. You have the options of paying with cash, check or credit card. We accept most major credit cards, VISA, Master Card, American Express and Discover Card.

Some people pay a retainer to their account at the beginning of their care. The cost for care are then drawn against credit on account. If you choose to leave a retainer of $500 a 10% discount will be applied to your office visits and any in house services you may have. The 10% discount is not, however, applied towards any products you may purchase.

A retainer increases commitment and follow-through, although the credit on your account is still under your control. You can receive a full refund on the unused portion at any time.

Another option is to sign a contract that allows charges to be made on your credit card for the costs of care. This arrangement makes appointments smoother and saves you time. At the end of your appointment you can get whatever you need up front and immediately leave. We will then send you a receipt in the mail with an itemized statement.

You are responsible to know what your insurance covers. This office does not accept insurance assignment. This means that you must submit receipts to your insurance carrier for reimbursement. This is a simple process: fill out your insurance forms, keep multiple copies in a file, staple a copy to your receipt from this office, and mail these to your insurance carrier.

Personal Injury

If your injuries were sustained in an auto accident or are due to another person's liability, you have suffered a personal injury. We will bill and correspond directly with YOUR insurance carrier or your attorney, if you decide to retain one. We will not bill a third party insurance company. The insurance companies do not cover supplements.

As a courtesy, we will allow you to carry a balance on your account only if you agree to a lien that insures your balance will be paid in full. You will need to pay for the cost of filing the lien ($100) on your first visit. ***Any bills not covered by your insurance carrier are your responsibility.***

Worker's Compensation

If you have been injured in the course of your work, your care will be considered a Worker's Compensation (WC) injury. We will bill and correspond with your WC carrier directly and you will not be directly responsible for the costs of your care. Supplements are not covered under WC.
You are, however, responsible for reporting the injury to your supervisor, or employer, and filling out the necessary paperwork. If you have not fulfilled those requirements your care will be on a cash basis. ***Any bills not covered by your insurance carrier are your responsibility.***

Medicare

Medicare is theoretically covered for chiropractic care. In reality, there are a number of restrictions that severely limit coverage. Medicare coverage for chiropractic care is only valid if the need for care can be demonstrated as medically necessary through x-ray findings. Medicare does not pay for these x-ray films. The policy regarding the number of visits allowed is currently under review by Medicare. Since I do not accept assignment, all charges are your responsibility regardless of whether or not Medicare pays your claim.

Diagnostic work-ups, including history, physical exam, laboratory procedures, and supplements are not included. Secondary insurance may make up the difference. You are expected to pay in full for services as they are rendered. As a courtesy to your, we will send a copy of your billing to Medicare for reimbursement.

Appointment Cancellations

Please note (*AND* initial on the line that you read and understand our policy) that there will be a $40.00 charge for appointments missed without 24-hour prior notification. ________________

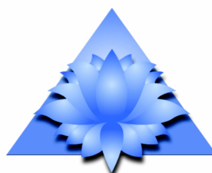
An interest charge of 2% may be applied to all past due balances. (P.I. and Workmen's Comp cases are excluded until insurance payment is received in full).

I, ___________________________________, have read, understand, and agree to the financial
(Please Print Name)
Policies as stipulated above.

Signature____Date________________

The undersigned person, from this office, has explained the financial policies, as well as the above named patient's options and responsibilities.

Signature____ Date________________



Protocol for Preservation of Patient Records

Pursuant to ARS 32-3210 and the requirements of the State of Arizona for the preservation of patient records, this documents the intended to inform all patients of The Elements of Health of their rights and obligations.

Patients or their representatives may request copies of their records, in writing. The Elements of Health agrees to comply with Arizona law for the production of these records and will timely respond to any reasonable requests.

The Elements of Health will maintain your records for a period of seven (7) years following your last date of service. After 7 years from the last date of service, The Elements of Health reserves the right to destroy your records. Should The Elements of Health exercise that right, The Elements of Health will first attempt to contact you and inform you of your right to obtain a copy of these records. The Elements of Health will attempt to contact you by regular mail, at your last known address, and will give you thirty (30) days to request that your records not be destroyed. If you do not respond to this notice, you will be waiving your rights to have your records preserved.

Should The Elements of Health cease to practice or sell the practice to another health care professional, The Elements of Health will notify all eligible patients, by regular mail, concerning the location of their records and how they may request copies of those records. The required notice will be sent to each eligible patient's last known address.

____
Patient Signature
I acknowledge receipt of this document

Acknowledgement and Agreement:
Patient's Protocol for Records Preservation

I, ____________________________, patient of The Elements of Health, do hereby acknowledge I have read and understand the doctor's protocol for the preservation of patient records. I agree to inform The Elements of Health of any address changes and acknowledge that all requests for records, either by me or by my representatives, must be in writing. I agree that the doctor's office may comply with all statutory notification requirements to me by regular mail to my indicated address.

Signature of Patient_______________________________________Date_____________________

Address of Patient ____

City_______________________________State_______________Zip Code__________________

DISCLOSURE & CONSENT for CHIROPRACTIC ADJUSTMENTS AND CARE

TO THE PATIENT: You have the right as a patient to be informed about your condition and the recommended chiropractic adjustments and other physical procedures to be used so that your may make the decision whether or not to undergo the procedure after knowing the potential risks and hazards involved. This disclosure is not meant to scare or alarm you: it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

I hereby request and consent to the performance of chiropractic adjustments and other procedures, including various modes of physical therapy and diagnostic X-rays, on me (or the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic or those working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as a backup for the Doctor of Chiropractic named below.

I have had the opportunity to discuss with the Doctor of Chiropractic named below, my diagnosis, the nature purpose of chiropractic adjustments and other procedures and alternatives.

I understand and I am informed that, in the practice of chiropractic there are some risks to exam and treatment including, but not limited to, fractures, disc injuries, strokes, dislocations, sprains and increased symptoms and back or no improvement of symptoms or pain. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

I have read, or have had red to me, the above consent. I have also had an opportunity to ask questions, and all my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan. I intend this consent form to cover the ensure course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To be completed by the patient

____
print name

____
signature of patient

____
date signed

To be completed by the patient's representative, if necessary, e.g., if the patient is a minor or physically or legally incapacitated:

____
print name of patient

____
print name of patient's representative

____
signature of patient's representative

as:______________________________
relationship or authority of patient's representative

____
date signed

To be completed by doctor or staff

______________________________ ____________________
witness to patient's signature date