CONSENT DOCUMENT & SIGNATURE FORM

Asula Wellness Center

THIS AUTHORIZATION SHALL REMAIN IN EFFECT AS STATED HERE UNLESS CHANGED IN WRITING BY THE PROVIDER OR PATIENT.

Please read to the end of this document and complete the Signature Form on the last page. The Signature Form must be signed prior to any treatment.

24 HOUR CANCELLATION NOTICE REQUIRED
A 24 hour cancellation notice is required for any scheduled appointments at Asula Chiropractic and Wellness Center (ACWC or Asula), including gift certificate sessions. We do this so that we can best accommodate all of patients and clients. **Rescheduled, missed or no show appointments will result in your being charged a $40 cancellation fee unless the appointment can be filled**. Emergency cancellations are determined at the discretion of ACWC. Email and text reminders can be set up for your account as a courtesy, but Asula cannot guarantee the accuracy of delivery. **You are ultimately responsible for keeping track of scheduled appointments.**

If you have been sick with a fever or vomiting within 24 hours of your scheduled appointment, please contact our front desk so we can get your appointment rescheduled.

SEXUAL HARRASSMENT POLICY
Sessions at Asula are strictly therapeutic. Any sexual remarks or advances will terminate the session and you will be liable for payment of the scheduled treatment.

FINANCIAL POLICY
Asula's financial policies are as follows:

- For your convenience, we are able to store a credit card on file for any balances.
- Estimated deductible, coinsurance, copays and self-pay will be collected at time of service.
- Statements will be mailed for any remaining balance due.
- Receipts will be e-mailed out upon request only.
- A late fee of $10 will be added to accounts 60 days after our initial request for payment.
- A collections fee of $25 will be added to any account over 90 days outstanding after our initial request for payment and then forwarded onto a collections agency.
- Labs have a separate payment policy that will be addressed if/when completing a lab.
- Please contact the billing department to make payment arrangements if the cost of the care received creates a financial burden for you.

CHIROPRACTIC, MANUAL THERAPY AND MASSAGE THERAPY INFORMED CONSENT TO TREAT

Chiropractic examination and therapeutic procedures (including spinal adjustment, ultrasound, heat application, electrotherapy, manual muscle therapy and prescribed exercises) are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. Side effects include, but are not limited to: soreness, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms. More serious complications are extremely rare and their association with spinal adjustments is debated. These complications include: stroke, neurologic impairment, injuries to the spinal discs, and spinal fractures. Serious complications are estimated to be in the range of 2 incidents per million for adjustments of the neck and 1 per

million for adjustments for the low back. I agree to save, hold harmless, discharge and release ACWC from any and all liability, claims, causes of action, damages or demands in connection with Chiropractic care, Massage Therapy and/or Therapeutic Activities.

UNDERSTANDING INSURANCE AND TREATMENT PLANS: Our mission at Asula is to provide well-balanced care. Your treatment, coordinated by our skilled chiropractors, includes more than chiropractic adjustments/spinal manipulations. Additional hands-on therapies, billed and prescribed under the chiropractor's license, are often provided in order to treat you with gentle, effective care designed to address all root factors contributing to your ailment in order to restore function. We believe in our multifaceted approach to treatment. If you are working with an insurance policy we are obligated to honor the rules of your contract. Some policies may cover these additional therapies such as manual therapy (massage) or exercise therapy, but they must be prescribed by the attending chiropractor as part of the treatment plan. The office team will work together to help you understand the benefits included on your specific policy. You can also discuss your coverage with your D.C. They will design a treatment plan that would best suit your condition and help you understand what would be covered by insurance and what services would need to be paid for out of pocket. All services are optional.

MAINTENANCE CARE VS. GOAL-DIRECTED CARE: Your care at Asula is goal directed. For this reason although your insurance policy may quote up to a certain number of visits per year, keep in mind that this number is not meant to be regarded as a yearly "target." Many insurance companies state in their policies that they will not pay for maintenance or preventative care. This means you are not allowed to just come in for regular wellness visits or preventative care. If you have an injury, ailment or pain you can come see your chiropractor and start a treatment plan. This plan could last anywhere from a single visit to several months of treatment based on the severity of the condition. Many insurance companies require evidence based treatment; meaning they feel treatment for conditions should reflect what research shows are typical for this condition. What this means for you as a patient is that if you need treatment past the recommended time frame your insurance may ask for more information, or possibly not cover your continued treatment.

For example: Cervical Sprain Strain is regarded by EviCore National (a Managed Care Organization) as a condition that research shows typically takes 9-12 weeks to resolve with conservative care, unless any other complicating factors are present. They prefer treatment plans, based on your diagnoses, to reflect what is a typical treatment length for that condition. Once a patient has reached full function they are to be released from care. Then they can start a new treatment plan if there is a new injury, or an exacerbation of a prior injury or condition. If a patient does not make a recovery within the recommended treatment time, they are to be referred to another specialist to further evaluate the condition.

MANUAL THERAPY AT ASULA: Due to the fact that Manual Therapy sessions are often part of the prescribed treatment plan, sometimes patients misunderstand and think their insurance policy has separate massage benefits. While a few insurance policies do have separate massage benefits, if you are having Manual Therapy sessions at Asula it can only be billed through your chiropractic and/or physical therapy benefits. Our Licensed Massage Therapists are dually licensed as Chiropractic Assistants but are not credentialed with the insurance panels. You are not able to schedule Manual Therapy appointments independently outside of your prescribed treatment plan as they must be prescribed by your treating D.C. in order to be covered by your insurance policy. Manual Therapy sessions are not a substitute for medical examination, diagnosis and treatment.

SCHEDULING APPOINTMENTS: Any 60min therapeutic modality session should reflect the treatment plan set by your Prescribing DC during your most recent chiropractic follow-up. If you have any questions or concerns about your visits please address them with your DC. Our front desk team will refer to the treatment plan notes left by the doctor to schedule your visits. In some instances clarification may need to be made with the DC and/or billing team before your appointment is scheduled.

EXPLANATION OF BENEFITS “BILLING PROVIDER”: “PRESCRIBING DC” VS. “SUPERVISING DC:” Your “Prescribing DC” is the Asula chiropractor who coordinates your care and whom you see during your follow-up appointments. The “Supervising DC” is one of Asula’s staff chiropractors who are responsible for monitoring the therapeutic modalities performed by Chiropractic Assistants during your appointment. The Supervising DC must be physically present in the clinic and the position rotates twice per day. Any treatment performed by a Chiropractic Assistant is billed under the scheduled Supervising DC. For this reason, the “Billing Provider” on your Explanation of Benefits (EOB) may not always be your Prescribing DC. You can verify the names of the Asula chiropractors on our website under “who we are” / “bios”.

MASSAGE THERAPY AT ASULA:
Patients may also schedule Wellness Massage sessions at Asula if they are paying out of pocket for the visit and not billing insurance. Massage in general provides benefits of stress reduction, relief from muscular tension, spasm, or pain, and it increases circulation and energy flow. Massage therapists do not diagnose illness or disease, perform any spinal manipulations, nor do they prescribe any medical treatments. Wellness massage is not a substitute for medical examination and you should see your primary caregiver for those services. The therapist must be aware of all health conditions due to certain contraindications or cautions for massage so please disclose all such conditions on the intake form. You are responsible to update any changes to your health in future sessions. If at any time during the massage the client or therapist is uncomfortable for any reason, they shall immediately say so and will decide if the session should continue. Sexual advances of any kind will not be tolerated.

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patients named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tiu-Nai (Oriental massage), Oriental herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of the treatment, other side effect and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Oriental Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then know is in my best interest. I understand that results are not guaranteed.

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I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment

NATUROPATHIC MEDICINE THERAPIES INFORMED CONSENT TO TREAT

GENERAL INFORMATION: ACWC is an integrative wellness clinic which offers a number of modalities. Due to the diversity of modalities offered at ACWC, your treatment may include any or all of the following general modalities: Naturopathic Medicine, Physical Medicine, Therapeutic Exercise, Homeopathy, Psychological Counseling, Nutritional Counseling and Bio-Identical Hormones.

METHODS, PROCEDURES AND THERAPEUTIC APPROACHES: Clinicians may perform any of the following procedures as necessary to give proper assessments, determine treatment approaches, treat or otherwise address your health concerns.

GENERAL DIAGNOSTIC PROCEDURES: Including but not limited to venipuncture, pap smears, radiography, blood labwork, urine labwork, general physical exams, neurological and musculoskeletal assessments.

HERBS / NATURAL MEDICINE: Prescribing of various therapeutic substances including plants, minerals, and animal materials. Substances may be given in the form of teas, pills, powders, tinctures (may contain alcohol), topical creams, pastes, plasters, washes, suppositories, or other forms.

PHARMACEUTICAL MEDICATION: Your physician may prescribe medication that is within the scope of practice.

POTENTIAL BENEFITS: Restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

POTENTIAL RISKS: Pain, discomfort, blistering, discoloration, infection, burns, loss of consciousness or deep tissue injury from needle insertions, topical procedures, allergic reactions to prescribed herbs or supplements, and aggravation of pre-existing symptoms.

Please read the following statements carefully.

I affirm that I have answered all questions pertaining to medical conditions truthfully and will update the practitioner of any changes in my health. I understand that if I have any prosthetics or surgical implants (including breast implants, an artificial joint, etc.), I should discuss this with the treating practitioner because it may affect care.

I understand that I play an important role in my own health care. Just as the patient can choose to discontinue care at any time, ACWC reserves the right to terminate a doctor-patient relationship if a patient is continually unable to comply with reasonable treatment plans.

If you have any further questions or concerns please discuss with treating Practitioner prior to final signature.

HIPAA NOTICE OF PRIVACY PRACTICES

This Notice of Privacy Practices describes how we 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. "Protected health information" is information about you, including the demographic information, that may identify you and that relates to your past, present, or future physical health or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and other outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your healthcare bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination of 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 and treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may be required so that your relevant protected health information can be disclosed to your health plan in order to obtain approval for the hospital administration.

Healthcare Operations: We may use or disclose, as-needed, your protected health information 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, employee training, and conducting or arranging for other business activities. For example, we may use a sign in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

The HIPAA Privacy Rule at 45 CFR 164.510(b) specifically permits covered entities to share information that is directly relevant to the involvement of a spouse, family members, friends, or other persons identified by a patient, in the patient's care or payment for health care. The covered entity may also share relevant information with the family and these other persons if it can reasonably infer, based on professional judgment that the patient does not object.

The Privacy Rule expressly permits a covered entity to use professional judgment and experience with common practice to make reasonable inferences about the patient's best interests in allowing another person to act on behalf of the patient to pick up a filled prescription, medical supplies, X-rays, or other similar forms of protected health information.

We may use or disclose your protected health information in the following situations without your authorization.

These situations include; as Required by Law, 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. Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the 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, authorization or opportunity to object unless required by law.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy. If you do not understand any information contained in the Notice of Privacy Practices, You may present your questions to the Medical Practice.

You may revoke this authorization, at any time, in writing, 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.

CONSENT FOR PURPOSES OF PAYMENT AND HEALTHCARE OPERATIONS

I, consent to ACWC's use and disclosure of my protected health information for the purpose of providing treatment to me, for purposes relating to payment of services rendered to me, and for general healthcare operations purposes. I understand that Asula's diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature of this document.

I understand that ACWC will be filing my insurance claims on my behalf as a courtesy. However, ultimately I am financially responsible for all charges on my account. If I do not have current insurance benefits, I am responsible for payment in full. I authorize my current insurance company to assign to ACWC all owed benefits.

For purposes of this consent, "Protected Health Information" means any information, including my demographic information, created or received by ACWC, that relates to my past, present or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my protected health information for the purposes of treatment, payment or healthcare operations of ACWC, but that ACWC is not required to agree to these restrictions. However, if ACWC agrees to a restriction that I request, the restriction is binding on ACWC.
I have been given the opportunity to review HIPAA Notice of Privacy Practices for ACWC prior to reviewing this document. The HIPAA Notice of Privacy Practices describes my rights and the Practice's duties regarding the types of uses and disclosures of my protected health information. Please notify the front desk if you wish to have a copy of our HIPAA Notice of Privacy Practices.

I have the right to revoke this consent, in writing, at any time, except to the extent that physician or ACWC has acted in reliance on this consent.

BENEFITS QUOTED DO NOT GUARANTEE PAYMENT. As with any medical claim, ultimately you are responsible for final payment for services. However in the event of claim denial(s) we will do our best to advocate on your behalf. A favorable outcome is much more likely if you are following your plan of care.

PLEASE CONTINUE TO THE NEXT PAGE TO INITIAL AND SIGN AGREEMENT TO THE CONSENTS LISTED ABOVE.

SIGNATURE FORM

THIS FORM MUST BE SIGNED BEFORE ANY TREATMENT IS PERFORMED.

Please Initial Below

_______________ **Asula Policies**

I have read and understood Asula Chiropractic & Wellness Center's policies regarding:

- *24 Hour Cancellation Notice*
- *Sexual Harassment*
- *Financial Policy*

_______________ **Payments**

For your convenience, we prefer to save a credit card to your account(s). Estimated deductible, coinsurance, copay and self-pay amounts will be collected at the time of service after we give you verbal confirmation of the amount due. A statement will be mailed for any remaining balances due once your claim has processed. If you prefer to not receive a statement by mail for any remaining balances due, please contact our billing team to set up a no-statement plan (please ask the front desk for their contact information).

If you prefer to not keep a credit card on file, please check the box below.

☐ Do not save my card on file. I will bring my preferred payment method to every visit for balances due.

_______________ **Informed Consent to Treat**

I understand the risks below with undergoing treatment. If requested I have received the additional explanation and clarification of risks.

_______________ **HIPAA Notice Of Privacy Practices**

I understand that I may ask questions to the Medical Practice if I do not understand information contained in the Notice of Privacy Practices.

_______________ **Consent For Purposes Of Payment And HealthCare Operations**

I understand that I am financially responsible for all charges on my account.

_______________________________ **Signature**

_______________________________ **Signature of Parent or Guardian**

_______________________________ **Date**

_______________________________ **Date**

OFFICE USE ONLY

☐ **Email Receipt**

☐ CC info has been stored on file or verified

Initials & Date: ______________________

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