Touch For Health

A Wholistic Family Wellness Center

Dr. Amy Redmond Brown, Chiropractor & Wholistic Lifestyle Coach
985-873-8100 904 Grand Caillou Rd Houma, La 70363

Consent For Use or Disclosure of Health Information

Our Privacy Pledge

Touch for Health, Inc. is very concerned with protecting your privacy. While the law requires us to give you a copy of this disclosure, please understand that we have, and always will, respect the privacy of your health information. There are several circumstances in which we may have to use or disclose your health care information. We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition. We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services. We may need to use your health information within our practice for quality control or other operational purposes. We may send you correspondence in the form of postcards, birthday cards, thank you letters, health information, newsletters, and other information. We may also send gift certificates for referring others patients to us. You have the right to refuse such correspondence. We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (§ 164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy practices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Appointment Reminders

We may need to use your name, address, phone #, e-mail, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information. If this contact is made by phone and you are not at home, a message will be left on your answering machine.
By signing this form, you are giving us authorization to contact you with these reminders and information.

I give my permission to discuss my health care information with:
Name_____
Relationshiop to patient_____

****

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice.

Print Name_____
Signature_____
Date_____
Authorized Provider Representative _____
Date_____

Touch For Health
Communication by Email, Text Message, and Other Non-Secure Means

It may become useful during the course of treatment to communicate by email, text message (e.g. “SMS”) or other electronic methods of communication. Be informed that these methods, in their typical form, are not confidential means of communication. If you use these methods to communicate with Touch for Health, Inc. there is a reasonable chance that a third party may be able to intercept and eavesdrop on those messages.

The kinds of parties that may intercept these messages include, but are not limited to:

- People in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages.
- Your employer, if you use your work email to communicate with Touch for Health, Inc.
- Third parties on the Internet such as server administrators and others who monitor Internet traffic.

CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NON-SECURE MEANS

I _____consent to allow Touch for Health, Inc. to use unsecured email and mobile phone text messaging to transmit to me the following protected health information:

- Information related to the scheduling of meetings or other appointments
- Information related to billing and payment

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this consent at any time by giving written notice to Touch for Health at the above address.

Signature:_____ Date:_____

Touch For Health - Fee Schedule and Financial Plans (Page 1)

We are committed to providing you with the best wholistic care possible in a caring environment and have established our financial policies to achieve that goal. Our goal is to help you move in the direction toward wellness and wholeness-balance body-mind-spirit. After the doctor goes over your recommendations to assist your body in functioning at its optimal potential, you will have the opportunity to ask any questions necessary to help you choose the payment option that works best for you. You will be expected to **pay** for your care **at the time service is rendered** unless other arrangements are made in advance. Other arrangements include our pre-payment bookkeeping discounts, Family Adjustment Plans (FAP), accident insurance coverage, or payments from an attorney. **We gladly accept Cash, Check, VISA, MC, Discover and Care Credit** (Care Credit applications in office)**. 2% processing fee for all credit card transactions over $1,000.**

Service	***Fee***
**** Initial Chiropractic Exam:*** Including consult, history, computerized Muscle balance & nervous system stress tests, posture evaluation, report of findings, recommendations. **** Progress Evaluation/consultation:*** (to monitor your progress, as Determined necessary by the doctor or requested by patient) **** Adjustments***	$150 $50 Birth till 5 years of age $50 $25 birth till 5 years of age $65 or see bookkeeping discounts below
**** Healthy Lifestyle Coaching:*** Consult/Results & recommendations	$100 initial visit $25 per 15mins
**** Hyperbaric Sessions (MHBOT) Mild Hyperbaric Oxygen Therapy***	$75 - 60 min & $100 - 90 min **or** see bookkeeping discounts for prepaid sessions
**** Infrared Sauna Sessions / Packages*** Package A Package B Package C	$1 per minute – minimal $20 $150 – 3 Hours (save $30) $225 – 5 Hours (save $75) $450 – 10 Hours (save $150)
**** Hair Analysis:*** For mineral deficiency/imbalance and heavy metal toxicity-includes lab work and consultation. **** Other lab tests: Blood, Urine, Saliva, Dutch Testing, DNA Kits, Allergy/Sensitivities***	$250 Dependent on tests ordered
**** Rolling Massage Table***	$20 – 15 min ($1 per min afterwards)

Payment Option (1)

_____Bookkeeping/pay as you go discount: $50.00 (you save $15 for each adjustment)

Payment Option (2)

_____Prepay 6: You pre-pay for 6 adjustments $270 ($45/adj.-you save $20 for each visit)

_____Prepay 12: You pre-pay for 12 adjustments $480 ($40/adj.-you save $25 for each visit)

_____Prepay 36: You pre-pay for 36 adjustments $1260.00 ($35/adj.-you save $30 for each visit)

Payment Option (3) (MHBOT) Mild Hyperbaric Oxygen Therapy Pre-pay frequent diver plans

_____Prepay 10: $600 for 60 min sessions or $800 for 90 min sessions
_____Prepay 20: $1100 for 60 min sessions or $1550 for 90 min sessions
_____Prepay 30: $1500 for 60 min sessions or $1875 for 90 min sessions
_____Prepay 40: $1800 for 60 min sessions or $2400 for 90 min sessions
_____Joint Sessions- This package is for any 2 or more people (i.e couples, workout partners, parent/child(ren),etc.) who wishes to have their sessions together, in the same chamber, at the same time. Each additional person is required to pay an additional 50% of the original plan.

(Continue on back)

Touch For Health - Fee Schedule and Financial Plans (Page 2)

Payment Option (4)

_____ ***Automobile Accident****: W*e will file claims to your insurance company, attorney, or other person's insurance company, **only if** they cover chiropractic care in our office and agree to mail payment to us (at the base rate of $65 per chiropractic adjustment, $100 initial exam, $180 per SEMG and report, and $90 per Infrared Thermal Scan and Report). Therapy is $25 per 15 min. session of intersegmental traction. You will be responsible for any unpaid balance within 30 days of a notice of denial or if max benefits have been exhausted. You will also be responsible at the time of service for any services provided not because of the accident/injury, and all products.

Payment Option (5)

_____ ***Family Plan Payment Agreement:***

- First time exams will be half-off regular price for additional designated family members who are not currently patients.
- The total number of adjustments purchased can be used by and distributed between any participating family members.
- Due to the greater bookkeeping discount of these family plans, only one receipt is provided at the time of original payment. ****You are responsible for keeping track of your correspondence and turning in visits to your insurance company for reimbursement as you use the visits.** We will provide you with all necessary insurance codes to file.

Names of participating family members:

_____ _____ _____

_____ _____ _____

Payment schedules for 2-6 family members			
Number of family members	Family Plan Fee, Number of Adjustments and Average Adjustment Price. Based on 26 adjustments per member and number of family members		
	$500 per additional family member		
2	$2080	(52)	$40.00 /adj
3	$2580	(78)	$33.08 /adj
4	$3080	(104)	$25.19 /adj
5	$3580	(130)	$27.54 /adj
6	$4080	(156)	$26.15 /adj

****You may choose to discontinue care at any time. There is no time limit to use your prepay visits. If you choose to discontinue care before all pre-paid adjustments/visits are used, your account will be adjusted at the base rate of $65.00 per chiropractic adjustment and $75 per 60 min and $100 per 90 min session for mild HBOT. Meaning, you are no longer under a discounted plan, every session becomes per session price. Any balance due to the office must be paid within 30 days. Refunds will, if applicable, be paid within 30 days.**

****I have read and understand the above policies. I have initialed the one I've chosen. I understand I can choose another plan at any time during my care, after completing previous plan.**

****If an insurance company or attorney is being billed for me, I authorize the release of any medical and/or other information necessary to process this claim for payment.**

Patient Signature _____ Date _____

Guardian's Signature _____ Date _____

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Today's Date_____/_____/_____ **How did you hear about us?**_____
Name_____ Age_____ Birthdate_____/_____/____Sex: M F
Address_____City_____State_____Zip_____
Home Phone ( )_____-_____Work Phone ( )_____-_____Cell Phone ( )_____-_____
Driver's License No.: _____ SS #: _____-_____ - _____ E-Mail _____
# of Children _____ # of Siblings _____ Pregnant? (Circle One) Yes No Unsure
Marital Status: (Circle One) Married Single Widowed Divorced
Occupation/Employer's Name and Address _____
Guardian/Spouse's Name_____Guardian/Spouse's Employer_____
Guardian/Spouse's Work # ( )_____-_____ Guardian/Spouse's Birthdate_____/_____/_____
Closest Relative not living with you _____ Phone # ( ) _____-_____
Address _____ City _____ State _____ Zip _____
Have you ever been to a chiropractor or wholistic physician? **Y N** If yes, name and reason for seeking care
_____

Your Health History

On a daily basis we experience **physical, chemical and emotional stresses** that can accumulate and result in serious loss of health potential. Most times the effects are gradual: not even felt until they become serious.

Please answer the following questions to the best of your ability & with as much detail as possible.
(Use back if more space is needed)

PLEASE DESCRIBE IN DETAIL REASON(S) FOR CONSULTING THIS OFFICE:
_____
_____
What do you believe caused this? _____
Did it happen suddenly or gradually over time? _____
When did you first notice the above? _____
What effort(s) have you taken to correct this? _____
What makes it better? _____
What makes it worse? _____

LIST MEDICATION/NATURAL SUPPLEMENTS: (Include **ALL** prescription drugs, antibiotics, hormones, over-the-counter medications, antacids, natural vitamins, minerals, herbs, or other supplements).

Product Name	Reason for Taking the Product	Date Started/If Stopped-When?

HISTORY OF PHYSICAL, CHEMICAL & EMOTIONAL STRESSES AND/OR TRAUMAS:

Were you vaccinated as a child? (Yes No) **Were you vaccinated as an adult?** (Yes or No)
List any negative effects you may have had after being vaccinated:_____
_____
Have you been involved in any car accidents? **Y N** When? _____ List Injuries: _____
_____
Have you had any surgeries? **Y N** When? _____ Describe: _____
_____
Have you had any physical injuries? **Y N** When? _____ Describe: _____
_____
Do/Did you suffer from any other emotional and/or physical traumas? **Y N** Describe: _____
_____
List any diseases, illnesses or any other conditions past and/or present and date of occurrence: _____
_____
Do/Did you smoke? **Y N** How much? _____ For how long? _____
Do/Did you drink alcohol? **Y N** How much? _____ How often? _____ For how long? _____
Have you ever used any illegal drugs? **Y N** What type? _____ When? _____
How many bowel movements do you have per: (circle one) day/week _____? Do you drink water? **Y N**
How many ounces per day? ____ Do you eat the 5-10 servings of fruits and/or vegetables per day? **Y N**
Do you exercise or do any physical activity? **Y N** Describe what and how often: _____
How do you rate your stress level at work/school? Circle one: (Least) **1 2 3 4 5 6 7 8 9 10** (Most)
How do you rate your stress level at home? Circle one: (Least) **1 2 3 4 5 6 7 8 9 10** (Most)
How do you rate your stress level overall? Circle one: (Least) **1 2 3 4 5 6 7 8 9 10** (Most)
Explain how you deal with the effects of stress in your life? (i.e.: exercise, pray, work in garden, drink, kick the dog, shout/curse at people,etc.)_____
Have you ever had mold exposure/flooded house? **Y N**
Do you have mercury/silver dental fillings? **Y N**
Have you ever had teeth removed or root canals? **Y N**
Do you have or ever had breast implants? **Y N**
Do you have any metal implants? **Y N** Where & what type of metal?_____
Date of last blood work_____ Ever took antibiotics? **Y N** Any other test results?_____
_____

Females ONLY: Check all that applies
[ ] irregular periods **[ ]** too frequent **[ ]** too heavy **[ ]** painful **[ ]** trouble concieving **[ ]** miscarriages

PLEASE LIST SIGNIFICANT FAMILY MEDICAL HISTORY AND HEALTH CONCERNS: (Please list who and what disease(s) and/or symptom(s), if any.
_____
_____
_____

OTHER COMMENTS OR CONCERNS:
_____

I UNDERSTAND THAT I AM FULLY RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED IN THIS OFFICE. I UNDERSTAND FEES ARE PAYABLE AT THE TIME EXAMINATIONS AND SERVICES ARE PROVIDED UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE. SHOULD MY ACCOUNT FALL DELINQUENT AND BE TURNED OVER FOR COLLECTION I AGREE TO PAY COLLECTION FEES, INCLUDING REASONABLE ATTORNEY FEES. IF INSURANCEC FORMS ARE BEING PRINTED AND/OR BEING BILLED FOR ME, I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS THIS CLAIM. THE STATEMENTS MADE ON THIS FORM ARE ACCURATE TO THE BEST OF MY RECOLLECTION AND I AGREE TO ALLOW THIS OFFICE TO EXAMINE ME FOR FURTHER EVALUATION:

Patient's (or Guardian) Signature _____Date_____

Rev. 05/14/20

Touch For Health
Lifestyle Questionnaire
Page 1

Name: _____ Today's Date: _____
DOB: _____ SSN: _____

How would you rate the following? (Please circle one for each):

Eating habits:	(Poor	Good	Excellent)	Emotional/Mental health:	(Poor	Good	Excellent)
Sleeping habits:	(Poor	Good	Excellent)	Home life:	(Poor	Good	Excellent)
Exercise habits:	(Poor	Good	Excellent)	Work/School life:	(Poor	Good	Excellent)
Spiritual life/habits:	(Poor	Good	Excellent)	Social life:	(Poor	Good	Excellent)
Physical health:	(Poor	Good	Excellent)	General health:	(Poor	Good	Excellent)

How many times per day or week?(Circle what applies)

Eat (Meals) 1-2/day 3-4/day 5+/day weekly___ **Snacks:** 1-2/day 3-4/day 5+/day weekly___
Time of first meal: _____ **Time of last meal:** _____

Soft/energy drinks:	1-2/day	3-4/day	5+/day	weekly___
Coffee:	1-2/day	3-4/day	5+/day	weekly___
Tea:	1-2/day	3-4/day	5+/day	weekly___
Artificial Sweeteners	1-2/day	3-4/day	5+/day	weekly___
Fast food:	1-2/day	3-4/day	5+/day	weekly___
Junk food:	1-2/day	3-4/day	5+/day	weekly___
Dairy (i.e.: Milk, cheese, ice cream, etc.):	1-2/day	3-4/day	5+/day	weekly___
Eggs:	1-2/day	3-4/day	5+/day	weekly___

Meat (chicken, beef, pork, fish, other seafood):	1-2/day	3-4/day	5+/day	weekly___
Vegetables	1-2/day	3-4/day	5+/day	weekly___
Fruits:	1-2/day	3-4/day	5+/day	weekly___
Nuts and Seeds:	1-2/day	3-4/day	5+/day	weekly___
Grains (brown/white rice, wheat, bread, crackers, oatmeal, tortillas, cake, cookies, barley, rye, corn, etc.):	1-2/day	3-4/day	5+/day	weekly___
Beans & legumes:	1-2/day	3-4/day	5+/day	weekly___

What best describes your diet? (Circle ALL that applies)

Lowcarb Lowfat Vegetarian Vegan Keto Paleo
SAD (Standard American Diet) Mediterranean IF (Intermittent Fasting) Organic

How often do you take time for **peaceful** activities? Explain what/how often? _____
_____
_____

List any **hobbies**: _____
_____

What **positive** lifestyle changes have you made recently? (i.e.: things you've started or stopped doing to improve you health and well-being)

_____
_____
_____

What other **lifestyle changes** do you want/need to make that you haven't yet? What is keeping you from doing this now? (i.e.: knowledge, desire, will power, support system, etc.) _____
_____
_____

List any other comments or concerns?
_____

Patient's (or Guardian's) Signature _____ Date:_____

Touch For Health
Lifestyle Questionnaire
Page 2

Name: _____ Today's Date: _____
DOB: _____ SSN: _____

Additional Patient Notes (cont.): _____
_____
_____
_____
_____
_____
_____
_____
_____

OFFICE USE ONLY

Doctor's Recommendations/Comments:_____
_____
_____
_____
_____
_____
_____
_____
_____
Lifestyle:_____
_____
_____
Supplements:_____
_____
_____
Other health professionals:_____
_____
_____

Doctor's Signature: _____

Revised 5/14/20

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Automobile Accident Questionnaire

Name: _____ Date: _____

Date of Accident: _____/_____/_____
Type of vehicle you were in: _____
Type of the other vehicle involved: _____
Were you the driver? _____
If you were the passenger, where were you sitting? _____
Were you wearing the seatbelt? _____ If so, what type? _____
Did the vehicle have an airbag? _____ If so, did it deploy? _____
What were the road conditions? (wet, dry, icy, gravel, etc.) _____
Did this accident occur in the course of your work? _____
Was your vehicle stopped or moving at the moment of impact? _____
Did you hit any part of the vehicle with your head and/or body? _____
_____
Were your head and/or body turned at the time of impact? _____
How much damage was sustained by the vehicles in the accident? _____
_____
Was your vehicle drivable after the accident? _____
Type of impact? (rear end, front, side, etc.) _____
Were you aware the accident was going to happen? _____
Did you brace yourself? _____
How many vehicles were in the collision? _____
Were you knocked unconscious? _____
How did you feel immediately following the collision? _____
_____
How did you feel hours and/or days later? _____
_____
Did you go to the emergency room? _____ If so, what was done at the ER? _____
_____
Have you had any treatment before coming to our office today? _____ If so, what? _____
_____
_____
How did you respond to the treatment? _____
Have you lost time from work due to this accident? _____
Have you had an automobile accident in the past? _____ If so, what areas of the body were injured?
_____
What symptoms, if any, were you having before this collision? _____
_____
Have you retained an attorney? _____ If so, what is his/her name and address? _____
_____

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Personal Injury Insurance Verification Form

Patient's Name:_____
Date of Accident:_____

Patient's Auto Insurance (Med-Pay)

Insurance Company: _____

Address (Billing):_____

_____

Insured's Name:_____

Policy Number:_____ Claim Number:_____

Adjuster's Name:_____ Adjuster's Phone #:_____

Third Party Information

Name of person at fault:_____

Insurance Company:_____

Address (Billing):_____

_____

Insured's Name:_____

Policy Number:_____ Claim Number:_____

Adjuster's Name:_____ Adjuster's Phone #:_____

Attorney Information

Attorney's Name:_____

Address:_____

_____

Phone Number:_____ Fax Number:_____

Contact:_____

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