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____

Rev. 7/5/18

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:___________________

Rev. 7/6/18

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_______/________/_______

WHO MAY WE THANK FOR REFERRING YOU? ____
Child's Name____ Child's SS#:_____________________________________
Age_____________Date of Birth_________________________Sex: **M F** Number of siblings__________________________________
Address____City________________State________Zip____________________________
Parent/Gaurdian's Email____
Home Phone ( )__________-_______________________Cell Phone ( ) __________-____________________________________
Mother/Guardian's Name ____Driver's License No.: ________________________
Mother/Guardian's Date of Birth______/______/______ Mother/Guardian's SS #: _______-_____-______
Mother/Guardian's Employer Name & Phone No. ____
Father/Guardian's Name ____Driver's License No.: _________________________
Father/Guardian's Birthdate ___ ___/______/_______ Father/Guardian's SS #: _______-_____ - _______
Father/Guardian's Employer Name & Phone No. ____
Has your child ever been to a chiropractor? **Y N** If yes, Name(s):____

Your Child's Health History

On a daily basis we experience **<u>physical</u>, <u>chemical</u> and <u>emotional stresses</u>** 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. (Use back if necessary.)

<u>PLEASE DESCRIBE IN DETAIL REASON(S) FOR CONSULTING THIS OFFICE</u> (if other than wellness care):
____
____
____

When did you first notice the above?____
What makes it better?____
What makes it worse?____

<u>THE BEGINNING YEARS</u>
Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

Type of birth: (Check all that apply) ☐Vaginal ☐Forceps ☐Breech ☐Cesarean ☐Home ☐Hospital ☐Birthing Center

Birth Weight: ________________________ Birth Length: ________________________

Problems during pregnancy:____
Problems during labor/delivery:____
Problems after birth:____
List ALL medications given to mother during pregnancy and at hospital:____
____
Obstetrician/Midwife: ___________________________________Pediatrician/Family DR.: ______________________________
Date of last visit to M.D.: ____________________ Purpose: ____
List any Cogential Abnormalities/Defects: ____
Infant Feeding: □ Breast For How Long: ____________ □ Bottle □ Formula – List all brands and reasons for switching:
____
List what age solid food was introduced? Baby cereals _________ Fruits _________ Vegetables __________
Meats __________ Nuts ________ Juice ________ Cow's Milk ________ Eggs ________
Other, please list: ____
List any reactions, allergies or intolerances noted:
____
____

Current eating habits: Does he/she consume any of the following and how often?

_____Dairy Products (milk, cheese, ice cream, etc.)	_______ per day	_______ per week	_______ per month
_____Soft Drinks/Sweetened juices, punch, etc.	_______ per day	_______ per week	_______ per month
_____Water	_______ per day	_______ per week	_______ per month
_____Sweets/junk food	_______ per day	_______ per week	_______ per month
_____Fast food	_______ per day	_______ per week	_______ per month
_____Vegetables	_______ per day	_______ per week	_______ per month
_____Fruits	_______ per day	_______ per week	_______ per month
_____Meats	_______ per day	_______ per week	_______ per month
_____Other	_______ per day	_______ per week	_______ per month

List any natural supplements, vitamins, minerals, or herbs and reasons for taking them: ______________________________
____

List any medications currently taking and reasons why:____
____

List past medications and reasons for taking them: ____
____

How many bowel movements does your child have: ______________________ per day or week?__________________________

Number of hours sleep per night _____________ Quality of sleep: □ Good □ Fair □Poor

On a scale of poor, good or excellent, describe your child's:

Diet __________________Exercise _________________Relationships w/others _______________General health __________________

List any hobbies or likes/dislikes:____

(Please circle either "Y" for yes or "N" for no to the following questions:)

Y N Has your child ever fallen/jumped from a height over three feet? (crib, bunk, bed, trees) If yes, explain:________________________
____

Y N Has your child ever been hospitalized or had surgery? If yes, explain:_______________________________________
____

Y N Has your child ever been involved in a motor vehicle accident? If yes, explain:__________________________________
____

Y N Did he/she suffer any other traumas? (emotional or physical) If yes, explain:___________________________________
____

Y N Was your child vaccinated? If yes, when and for what:____
____

Y N Has your child ever had a negative reaction to a vaccination? If yes, explain:____________________________________
____

Y N Has a family member ever had a negative reaction to a vaccination? (Such as death, seizures, autism, retardation, learning disabilities, weakened immune system, other) If yes, explain:____
____

Y N Has your child had any childhood illnesses? If yes, explain:____
____

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, X-RAYS AND SERVICES ARE PROVIDED UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE. X-RAYS REMAIN THE PROPERTY OF THIS CLINIC. SHOULD MY ACCOUNT FALL DELINQUENT AND BE TURNED OVER FOR COLLECTION I AGREE TO PAY COLLECTION FEES, INCLUDING REASONABLE ATTORNEY FEES. IF INSURANCE FORMS ARE BEING PREINTES AND/OR BILLED FOR ME, I AUTHORIZE THE RELEASE OF AMY M EDICAL OR OTHER INFORMATION NECESSSARY 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 MY CHILD FOR FURTHER EVALUATION:

Patient's (or Guardian's) Signature _______________________________________Date_________________________

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