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
Terms of Acceptance

As a **Wholistic Family Wellness Center**, we **focus** on **your ability to be healthy** & seek to identify the **cause** of disease & imbalances. Our **goals** are to address the issues that brought you to this office, and to offer you the opportunity of **improved health potential** and **wellness services** in the future.

Health: A state of **optimal physical, mental and social well-being**, not merely the absence of disease or infirmity. Wellness exists when all organs of the body function at 100% under the direction of your **Innate Intelligence. Body, mind and spirit in balance & harmony are what we are moving toward and wanting to maintain.**

Nutrition & Lifestyle: Recommendations are given about lifestyle habits and nutritional deficiencies/imbalances as determined by your lifestyle history (stress, exercise, eating habits, etc.) and testing. The purpose is to **provide** you with the **information & support** needed to **make healthier choices** to provide your body with what it needs to function optimally and/or to eliminate what is interfering with it's **potential to heal and function the way God designed it.** You can then **move in the direction of vibrant health & wholeness** in instead of dis-ease and death.

The Nerve System is used to **control** and **coordinate all body functions**. Normal free transmission of neurological impulses **(communication) between the brain and body are necessary for normal life expression, which is wellness.**

Subluxations of the spine caused by loss of normal alignment and function interfere with the normal transmission and physiology of the nerve system. This can **occur due to physical, chemical or emotional stresses and traumas.** As a result, there is a partial loss in the **connection** between your brain and body. This **causes Dis-ease** and **ill health**, **which in time may lead to abnormal life expression, symptoms, sickness, and loss of potential.**

Chiropractic Adjustments allows more normal function and alignment in your spine and helps the body to **restore communication.** It helps re-establish and maintain the CONNECTION between your brain and your body. You can then **function and express life better**, have a **greater resistance to sickness and disease** and **release the potential to heal, recover and move toward wholeness.**

Chiropractic is not a form of medicine. Medicine specializes in the treatment of symptoms & diseases. **Chiropractic** specializes in the **restoration and expression of life** by restoring the connection and communication between the brain and the body.

We Do Not Diagnose, Prognose, Treat or Cure Disease. We do not attack or suppress symptoms. If, during your care, you become concerned about your symptoms, we suggest you seek the help of a Medical Doctor whose focus is on symptoms, sickness and disease.

Our only goal is to restore the flow of God's Life Energy, the expression of the body's innate wisdom, and to educate you about healthy lifestyle choices. The power that created the body, which is the power that heals, is then released.
It is important that you understand both the objective and the method that we will be using to attain this goal so that we are working towards the same goal. With gratitude, Thanks for the opportunity to serve you! Dr Amy R Brown.

I, the undersigned, have fully read and understand the above statement and agree to receive care with the understanding.
Date: _____/_____/_____ Reason for seeking care: _____

Signature of patient/guardian: _____ Patient Name (please print): _____

Revised 5/16/18

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:_____

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. 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)**.**

Service	***Fee***
**** Initial Chiropractic Exam:*** Including consult, history, computerized Muscle balance & nervous system stress tests, posture evaluation, report of findings, recommendations, and community wellness classes offered. **** Progress Evaluation/consultation:*** (to monitor your progress, as Determined necessary by the doctor or requested by patient) **** Adjustments***	$100 $50 Birth till 5 years of age $50 $25 birth till 5 years of age $65 or see bookkeeping discounts below
**** Healthy Lifestyle Coaching:*** *C*onsult & recommendations &/or Results from testing- *These sessions can be used to help with diet, supplements, weight loss/gain, stress, birthing plans, children's health issues, drug free alternatives/natural solutions, hormones, or any other health topic/issue that you may want the doctor's knowledge, expertise, and/or recommendations on. Our goal is to help you move in the direction toward wellness and wholeness* ***- balance body-mind-spirit.***	$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***	$20 – 15 min ($1 per min afterwards)
**** Hair Analysis:*** For mineral deficiency/imbalance and heavy metal toxicity-includes lab work and consultation. **** Other lab tests: Blood, Urine, Saliva***	$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 $240 ($40/adj.-you save $25 for each visit)

_____Prepay 12: You pre-pay for 12 adjustments $420 ($35/adj.-you save $30 for each visit)

_____Prepay 36: You pre-pay for 36 adjustments $1080.00 ($30/adj.-you save $35 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.

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.

(*Continue on back)*

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

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 number of adjustments and number of family members		
	Option A (72 adj. each) *$750 per additional family member*	Option B (52 adj. each) *$600 per additional family member*	Option C (26 adj. each) *$400 per additional family member*
2	$3600 (144) $25.00 /adj	$3120 (104) $30.00 /ad	$1820 (52) $35.00 /ad
3	$4350 (216) $20.14 /ad	$3720 (156) $23.85 /ad	$2220 (78) $28.46 /ad
4	$5100 (288) $17.71/adj	$4320 (208) $20.77 /ad	$2620 (104) $25.19 /ad
5	$5850 (360) $16.25 /ad	$4920 (260) $18.92 /ad	$3020 (130) $23.23 /ad
6	$6600 (432) $15.28 /ad	$5520 (312) $17.69 /ad	$3420 (156) $21.92 /ad

****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 **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. (Use back if necessary.)

PLEASE DESCRIBE IN DETAIL REASON(S) FOR CONSULTING THIS OFFICE (if other than wellness care):

_____
_____
_____

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

THE BEGINNING YEARS

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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