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. 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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Consent Agreement to Treatment for HBOT

Please read and acknowledge each of the following statements by signing below.

• I understand that mild hyperbaric oxygen therapy is not intended to diagnose, treat, cure, or prevent disease. In addition, I recognize that while mild hyperbaric oxygen therapy may enhance healing, it does not replace a health professional's prescribed medications or recommended treatments. Health professionals prescribe mild hyperbaric oxygen therapy to address a wide variety of health issues; however, I acknowledge this therapy is only FDA approved for specific conditions.
• I understand that mild hyperbaric oxygen therapy uses an increase in atmospheric pressure in a sealed chamber to allow the body to absorb more oxygen (approximately 91%) at a cellular level to promote healing and wellness. I understand that the amount of atmospheric pressure used by Touch For Heath is 1.3 absolute atmospheres, or 4.4 psi.
• I understand that mild hyperbaric oxygen therapy is reported to be beneficial for a wide range of medical ailments, but no therapeutic outcomes can be guaranteed. I recognize that while the FDA recognizes specific conditions that directly benefit from mild hyperbaric oxygen therapy, there are many additional "off-label" conditions, which have been studied with positive results. As with any therapy, there are no guarantees as to any positive physical or emotional response, and the fees are for services rendered and not benefits received. I procure this therapy at my own risk. I understand that I may neither observe nor realize any benefit from the hyperbaric treatment. I understand that mild hyperbaric oxygen therapy is not a substitute for any medical treatment prescribed or suggested by my physician.
• I understand that as the chamber is pressurized and depressurized I may need to equalize the pressure in my ears to acclimate to the pressure changes and may experience "popping" in my ears. This is normal. If I am unable to equalize ear pressure and experience pain in one or both ears, I will immediately communicate the discomfort, so adjustments may be made to eliminate discomfort. If I am unable to equalize the pressure in my ears, the therapy session may be terminated or modified—therapy may be administered at a lower atmospheric pressure.
• I understand that I may experience minor ear, sinus, or other discomfort. I acknowledge that a Touch For Health staff member is present to work with me to provide comfort in the event of any discomfort I may experience, but that the staff member may not be a trained health care worker. I understand that Touch For Health, Inc. is not a medical facility.
• I attest that I am a consenting adult over the age of 18 and that I agree to enter (and/or permit my child to enter) the mild hyperbaric chamber on my own free will. I am entering the chamber at my own risk and without the coercion or sales pressure from any associate or employee of Touch For Health, Inc. 904 Grand Caillou Rd. Houma, La. 70363 985-873-8100.
• I am not aware of any physical conditions of which I suffer or have that would or should preclude my undertaking this therapy. If I have any doubts, concerns, or questions, I will, prior to undertaking such therapy, see and obtain medical advice from a licensed physician. In addition, I understand that it is my sole responsibility to update Touch For Health, Inc. regarding any changes to my medical status or medications each time I receive treatment.

Acknowledgement of Policies

• I agree not to bring food or drink into the chamber. I understand that the exception to this rule is if I have diabetes, in which case I will bring an appropriate snack to each session in case my blood sugar drops during treatment. I also agree not to bring flammables into the chamber.
• I understand that it is important to have eaten food at least one hour prior to treatment.
• I understand that smoking and nicotine interfere with the benefits of mild hyperbaric oxygen therapy. Therefore, I agree to abstain from smoking or using a nicotine patch 2 hours prior to my appointment time.

By signing I attest to the fact that I have fully read, understood, and consented to this agreement in its entirety to treatment(s) in the mild hyperbaric chamber. I understand that by signing this I am assuming any and all risks associated with the administration of mild-pressure hyperbaric oxygen chamber therapy. I agree not to hold Touch For Health, Inc. liable for any harm I may associate with the treatment(s) in the mild hyperbaric chamber.

Print Name _____ Signature_____ Date _____
Authorized Provider Representative _____ Date _____

Disclaimer—The content and information provided by Touch For Health, Inc is for informational and educational purposes only and is not intended as medical advice. Please consult a physician before pursuing any form of medical treatment, including hyperbaric oxygen therapy. No claims are made as to the effectiveness of hyperbaric oxygen therapy in the treatment of specific conditions. Touch For Health, Inc. makes no express or implied warranty regarding any health benefits that may be derived from the use of a hyperbaric chamber. A portable hyperbaric oxygen chamber is a Class II Medical Device, and as such its use or purchase requires a physician's prescription

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Mild HBOT Intake Form

Please fill out completely and answer all the questions to the best of your ability.

Name_____ Home Phone_____ Cell_____
Today's Date_____ Date of Birth_____ Age_____
Email_____ Address_____
Occupation_____ Male ___Female___ Married____ # of Children_____

Please fill out completely and answer all the questions to the best of your ability.
How did you hear about Mild Hyperbaric Oxygen Therapy at Touch for Health?_____
Referring Physician_____Phone_____
Additional Physician_____Phone_____
Address_____
What is the reason you seek hyperbaric Oxygen Therapy? _____
_____

Please fill out completely and answer all the questions to the best of your ability.

Medical History and Medications
Are you currently undergoing medical treatment? Please Describe._____
_____
If you exercise on a regular basis, how frequently? _____
If you use tobacco, how frequently? _____ If you use alcohol, how frequently?_____
Are you pregnant or think you may be pregnant? __ No ___ Yes
Have you ever had any ear problems? No ____ Yes____ Please Describe._____
_____
Do you have any problems with your ears when you fly? No ___ Yes ___

Have you ever had or been suspected of having any of the following conditions? Check all that apply.

- ___Congenital Spherocytosis
- ___COPD/Emphysema with air trapping
- ___Untreated Pneumothorax
- ___Upper Respiratory Infections—URIs can make it difficult for the patient to clear his/her ears, which can result in inflammation of sinuses, or sinus squeeze.

Are you currently prescribed or taking any of the following medications? Check all that apply

- ___Disulfiram (Antabuse®)—an oral tablet used to treat chronic alcoholism
- ___Bleomycin—a chemotherapy agent
- ___ Cis-Platinum---a chemotherapy agent
- ___Doxorubicin (Adriamycin®)—a chemotherapy agent
- ___Mafenide Acetate (Sulfamylon®)—a topical cream used to prevent and treat bacterial or fungal infections

Have you ever had radiation therapy? No___ Yes ___ Please Describe._____
_____
Please List types of surgeries and dates._____
_____
_____
_____

Have you ever been hospitalized for serious illnesses within the last 5 years? No__ Yes__ Please Describe & include dates:_____
_____
_____
_____
Please list any allergies._____
_____

Are you taking any medications (Prescription or over-the-counter)? No___ Yes___

List Medications(s): **To Treat:** **Duration/for how long?**

_____

_____

_____

_____

Were you previously taking any medication regularly? Yes___ No ____ Please list what and for how long you were taking._____

_____

_____

Have you had or do you currently have any of the following?

- ☐ Acute Respiratory Illness
- ☐ Allergies
- ☐ Anemia
- ☐ Angina/Chest Pain
- ☐ Anxiety
- ☐ Arthritis
- ☐ Aspergers/Autism
- ☐ Asthma
- ☐ Back pain
- ☐ Bells Palsy
- ☐ Cancer or Malignant Tumor
- ☐ Cataracts
- ☐ Chemical Sensitivity
- ☐ Chemotherapy
- ☐ Chronic Back Problems
- ☐ Chronic bronchitis
- ☐ Chronic Fatigue
- ☐ Claustrophobia Or Panic Attacks
- ☐ Congenital Spherocytosis
- ☐ Crohns Disease
- ☐ COPD/Lung Disease
- ☐ Dentures
- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Ear Infections (Frequent)
- ☐ Ear trauma
- ☐ Emphysema
- ☐ Epilepsy or Seizure disorder
- ☐ Exposed Bone
- ☐ Fainting
- ☐ Fever-Current
- ☐ Fibromyalgia
- ☐ Glaucoma
- ☐ Heart Attack
- ☐ Heart Disease/Heart Problems
- ☐ Heart Failure
- ☐ Heart Murmur
- ☐ Hepatitis/Jaundice
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ HIV Infection/AIDS
- ☐ Infections (Frequent)
- ☐ Lung Infections (frequent)
- ☐ Lyme Disease
- ☐ Malignant Disease
- ☐ Mitral Valve Prolapse
- ☐ MRSA (Staphylococcus)
- ☐ Multiple Sclerosis
- ☐ Kidney Disease
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Infections (frequent)
- ☐ Lyme Disease
- ☐ Mitral Valve Prolapse
- ☐ Malignant Disease
- ☐ MRSA (Staphylococcus)
- ☐ Multiple Sclerosis
- ☐ Neurological Disease
- ☐ Optic Neuritis
- ☐ Pneumothorax/Collapsed Lung
- ☐ Pregnant-Current
- ☐ Pulmonary Cyst or abscess
- ☐ Radiation Therapy
- ☐ Recent Dental Surgery
- ☐ Recent Weight Loss
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Ringing in the ears
- ☐ Rosacea
- ☐ Sinusitis
- ☐ Sleep Apnea
- ☐ Stomach Problems/Ulcers
- ☐ Stroke
- ☐ Swollen Ankles
- ☐ Thoracic Surgery
- ☐ Thyroid Problems
- ☐ Traumatic Brain Injury
- ☐ Tuberculous
- ☐ Upper Respiratory Infections
- ☐ Viral Infection-current
- ☐ Other_____

I certify that all of the information is true and accurate. I **agree to advise Touch For Health of any changes in my patient information, medical status, medications, allergies, or any other information concerning my therapy.**
I have reviewed the Touch For Health Consent Agreement. I acknowledge the possible, but rare, side effects as indicated and am aware of contraindications to oxygen therapy. I also understand my responsibilities as a Touch For Health Patient in terms of preparing for my therapy sessions.
I have reviewed the fee schedule and understand that I am responsible for payment on the date of service.
Signature_____ Date_____

CONSENT TO TREATMENT OF A MINOR

I hereby authorize staff at Touch For Health to administer mild hyperbaric therapy to
Minor's name_____Guardian's Signature_____Date_____
Witnessed by_____