

## FINANCIAL POLICIES

**Insurance Patients:** Your insurance policy is a contract between you and your insurance company. Neither Apex Wellness Center, nor any of the providers are third parties to your insurance policy. As a courtesy to you, we can call your insurance company to verify your benefits and coverage prior to your first appointment. **Please be aware that this verification is an estimation of benefits and not a guarantee of payment.** Additionally, as a service to you, we can bill your insurance for your visits. It is your responsibility to provide our office with your insurance details, current address, birthdate and present your insurance card to us, prior to your first visit, so we can bill your insurance carrier completely and accurately.

Your insurance provider may pay only a portion of the charge for your treatment. All co-payments, co-insurance, services, products, supplies and balances not covered by your insurance are due and payable at the time of each visit. If any amounts or fees are unknown at the time of service, patients with unmet deductibles will pay \$75.00 per visit and patients with co-pays or co-insurance will pay \$20.00 per visit. Any outstanding balance on your account will be due at the start of your next visit. You may be subject to finance charges and monthly fees if your account balance is left unpaid for 90 days from the date of service.

Additionally, your insurance company may not pay for services if your treatment plan is not followed, thus it is your responsibility to schedule and attend all of your appointments accordingly.

Alternatively if, after your insurance is billed, there is credit on your account, you may choose to use the balance toward future products and/or services or have a check mailed to you upon your request.

Please notify Apex Wellness Center immediately if your insurance coverage details, address, phone number, or e-mail address changes.

**Cancellation Policy:** There is an appointment cancellation fee for each no-show and appointment cancellation with less than 24 hours notice:

### **Chiropractic, Naturopathic, Acupuncture and Massage: \$40 per missed appointment**

**Fees will be collected in full prior to your next appointment with us.**

(see below for more payment information.)

**Late Arrivals:** Please be advised that we do our best to accommodate for extenuating circumstances, However, arriving late for your appointment can disrupt your practitioner's schedule of subsequent appointments. If you arrive late for your appointment, you will still be charged in full and may have less time for your appointment.

**Patients arriving considerably late, (ie. 10 minutes or more for a chiropractic appointment, 15 minutes or more for a massage, naturopathic or acupuncture appointment) may have their appointment canceled and will need to reschedule.** In this case, a cancellation fee, as described above, may apply.

**Cost of Goods and Services:** Patients are financially responsible for the cost of supplements, herbal products, supplies and equipment to be paid at the time of pick up. Special orders must be paid at the time the order is placed. We accept the following forms of payment: cash, check, health savings and reimbursement account cards, debit and credit cards, with the exception of American Express. For your convenience, debit and credit card payments can also be processed over the phone. It is our policy to not accept out of state checks. Please note, there is a \$30 fee for returned checks.

\_\_\_\_\_  
Patient Signature (or Guardian if patient is a minor)

\_\_\_\_\_  
Date

## INFORMED CONSENT TO TREATMENT

**We would like you to be informed of your rights and responsibilities as well as of the benefits and risks of the services and therapies offered at Apex Wellness Center. While the chances of experiencing any of the complications listed below are small, it is the practice of this clinic to inform patients about them. Please discuss any questions or concerns you may have with your practitioner.**

### **Chiropractic Care**

Chiropractic examinations and therapeutic procedures (including chiropractic adjustments, ultrasound, heat and cold application, electrotherapy, cold laser therapy, taping procedures, and soft tissue therapies) are considered safe and effective methods of care. However, there are occasions when a procedure intended to help may have complications. These complications may include but are not limited to soreness, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms. More serious complications, such as stroke and disc herniations, are extremely rare. If you choose to not seek chiropractic care today, then your condition may take longer to improve. It is possible that your condition may heal on its own or not heal without treatment.

Please inform your practitioner if you are pregnant and of any changes in your symptoms, medication, or diagnoses by other doctors at the time of your care. If you would like additional information on side effects and complications that could result from treatment or product use, please discuss these with your practitioner.

### **Massage Therapy**

I understand that the massage and bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort.

I further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any physical or mental ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the sessions should be construed as such.

Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical history and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

I understand that I may also be given cupping (the application of glass cups with vacuum to the skin) and/or gua sha (rubbing of the skin with a smooth object such as a porcelain spoon) as part of my treatment. I am aware that these treatments are intended to cause minor skin discoloration and though visible, are usually not painful. However, certain adverse side effects may result from this treatment. These could include, but are not limited to: bruise-like marks on the skin, sore muscles or aches, minor nausea and possible temporary exacerbation of symptoms experienced prior to the treatment. I understand that I may refuse the treatment or stop the treatment at anytime for any reason.

I understand that I should avoid hot showers, baths, saunas, hot tubs, ice therapy, body scrubbing and aggressive exercise for 24 hours following cupping or gua sha treatments. I also understand that exposure to hot, cold or windy conditions can produce undesired effects and I should avoid such extremes. I understand that I should avoid excess caffeine and alcohol and I should consume plenty of clean drinking water (room temperature to lukewarm is optimal).

## INFORMED CONSENT TO TREATMENT CONT'D

### Naturopathic

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopathic Doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity.

Dr. Angela Cortal will take a thorough case history, do a complete physical examination as indicated, and may request blood and urine samples. If your case requires, the physical may include more specific examinations such as gynecological, rectal, prostate or genital exams. It is very important therefore that you inform Dr. Cortal immediately of any disease process that you are suffering from, any allergies you may have, and if you are on any medication or over the counter drugs. If you are pregnant, suspect you are pregnant or you are breast-feeding; please notify Dr. Cortal immediately. Please be aware of the health risks inherent to treatment by Naturopathic medicine. These include but are not limited to: aggravation of pre-existing symptoms and allergic reactions to supplements or herbs.

With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above. I intend this consent form to cover the entire course of treatment.

### Acupuncture

Please see Mary Jean Brinkman to obtain and sign a separate Acupuncture Informed Consent to Treat and Arbitration Agreement form.

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By signing below, I acknowledge that I have read all of the policies and statements provided here and understand my rights and responsibilities as a patient at Apex Wellness Center. **(Further explanation of patient rights and responsibilities in accordance with HIPAA is available for your reference at your request)**. I also understand the benefits, side effects and risks of treatments offered by the practitioners here and, furthermore, understand that there is no guarantee for a specific cure or result. I understand that it is my right to withdraw my consent and to discontinue treatment and participation in any of the above mentioned procedures at any time.

This form is not intended to be a comprehensive explanation of all risks and benefits of treatments, but to serve as a guideline. I will speak directly with my practitioner/s should any questions or concerns arise.

**I have reviewed and understand the "Notice of Privacy Practices and Patient Rights and Responsibilities Statements", in accordance with HIPAA, from Apex Wellness Center and hereby consent to treatment:**

\_\_\_\_\_  
Patient Name (Please print)

\_\_\_\_\_  
Relationship to Patient (if not self)

\_\_\_\_\_  
Patient Signature (or Guardian if patient is a minor)

\_\_\_\_\_  
Date

*Please be advised that while the practitioners at Apex Wellness Center may discuss your care and/or collaborate on your treatment plan, each practitioner may request or require additional information from you, based on your individual treatment plan, in order to be fully informed and provide you with the highest level and most comprehensive care possible.*