Mary DeRose, D.C.
Choices Integrative Healthcare of Sedona
95 Soldiers Pass Rd, Suite B
Sedona, AZ 86336

Terms of Acceptance

When a patient seeks chiropractic health care and I accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. My chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmary.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

I do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of chiropractic spinal examination, I encounter non-chiropractic or unusual findings, I will advise you. If you desire advice, diagnosis or treatment for those findings, I will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, I do not offer to treat it. Nor do I offer advice regarding treatment prescribed by others. **MY ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. My only method is specific adjusting to correct vertebral subluxation.

I, _____, have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____

Patient Signature Date

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ATTENTION NEW PATIENTS TO DR. DEROSE

The first visit with Dr. DeRose has two charges that will be billed to your insurance company. One of the charges is a new patient office visit that is a requirement by all insurance companies. This new office visit is considered a well office visit and is not covered by MOST insurance companies. This $50 charge will be discounted by Dr. DeRose to a charge of $25. The $25 charge is due at the time of the initial visit, unless other arrangements have been discussed with Dr. DeRose prior to that visit

I have read the above statement and understand it.

_____

Patient signature and date

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PATIENT INFORMATION:

Name (Last) _____ First _____ MI ____

Mailing Address _____ City _____ St ____ Zip _____

Local/Temporary/Visiting Address _____

City _____ State ____ Zip _____

Home Telephone ( ) _____ Local Telephone ( )_____

Fax Telephone ( ) _____ E-Mail Address _____

Date of Birth _____ Social Security Number _____

Marital Status S M W D Sex M F

WHO IS FINANCIALLY RESPONSIBLE?

Name(Last)_____ First_____
MI____

Mailing Address _____ City _____ St ____ Zip _____

Relationship_____

EMPLOYER INFORMATION:

Name: _____ Work Telephone ( ) _____

WHO SHOULD WE CONTACT IN CASE OF AN EMERGENCY?

Name: _____ Telephone ( ) _____ Relationship _____

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Acknowledgement of Receipt of Privacy Notice

Original to be maintained in Patient's permanent medical record.

Name of Patient:_____

I acknowledge that I have received a copy of the office's Notice of Privacy Practices.

_____ _____
Patient or legally authorized individual signature Date

_____ _____
Printed Name if signed on behalf of the patient Relationship to Patient
(parent, legal guardian, personal representative, etc.)

Names of Family Members and Friends to Whom Choices may provide Information

Currently we are prohibited from giving anyone who is not involved in your care any information about you. Examples of issues we see are:

1. We are prohibited from giving anyone else a prescription for you to be picked up by someone else.
2. We may not give a family member a copy of your lab results that are requested by you but picked up by, perhaps, your spouse.

Please list the person(s) who may be given health information about you. Think about giving Choices Healthcare permission to provide information to your spouse and/or child(ren).

You may provide information to the following persons:

_____ _____
Printed Name Relationship to Patient

_____ _____
Printed Name Relationship to Patient

_____ _____
Printed Name Relationship to Patient

_____ _____
Printed Name Relationship to Patient

_____ _____
Patient or legally authorized individual signature Date

_____ _____
Printed Name if signed on behalf of the patient **Relationship to Patient**

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Statement of Patient Financial Responsibility

Patient Name: _____DOB: _____

Choices Integrative Healthcare of Sedona appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill. Verification of insurance benefits does not release the patient or the patient's guarantor from responsibility for payment.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibility to Choices Integrative Healthcare of Sedona, for providing healthcare services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Choices Integrative Healthcare of Sedona, the full and entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Patient/Guarantor Signature _____Date_____

Co-Pay Policy

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

Patient/Guarantor Signature _____Date _____

Deductible Policy

Some health insurance carriers require the patient to pay a deductible before the insurance carrier will pay for services rendered. It is expected and appreciated that the patient pays their portion at EACH VISIT until the deductible is met for the year. Thank you for your cooperation in this matter.

Patient/Guarantor Signature _____Date _____

Consent for Treatment and Authorization to Release Information

I hereby authorize Choices Integrative Healthcare of Sedona, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

I further authorize Choices Integrative Healthcare of Sedona, to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

Patient/Guarantor Signature _____ Date _____

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Advance Beneficiary Notice

Medicare, Supplemental and private insurance companies requires issuance of an ABN whenever the medical service provider expects Medicare or other insurance companies might not pay for a medical treatment, service or supply. Providers make ruling based on Medicare Program and other insurance standards, which outline reasonable and necessary services. Medicare and other insurance companies can exclude payment for such items and services as eye examinations, tests related to screening procedures, chiropractic services, self-administered medications (typically non-injected medications) and immunizations.

I understand that I will need to sign an ABN, if I have Medicare, or an Advance Medical Services Payment agreement, if I have a replacement or private insurance, if the provider of services deems it necessary for me to do so. Doing so, I understand that I am ultimately responsible for any test, procedures or immunizations performed during my visit.

Patient/Guarantor Signature _____Date_____

Non-Sufficient Funds

I understand that if for any reason a check or credit card payment is denied or returned to Choices Integrative Healthcare of Sedona, I will be responsible to pay a $35 fee.

Patient/Guarantor Signature _____Date _____

Cancellation / No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24-hours prior to canceling your appointment.

I understand if I no show for two consecutive appointments, no show for three appointments or cancel for a total of four appointments, I may be discharged from care. I understand there is also a $25 charge per no show or late cancellation that will be billed to me by the practice.

Choices Integrative Healthcare of Sedona will notify you in writing, via certified mail, if you are discharged from care.

Patient/Guarantor Signature _____ Date _____

Self-Pay

I do not have health insurance and will be responsible for services rendered here at Choices Integrative Healthcare of Sedona. I agree to pay Choices Integrative Healthcare of Sedona, the full and entire amount of treatment given to me or to the above named patient at each visit.

Patient/Guarantor Signature _____ Date _____

Motor Vehicle Insurance (PIP)

I do not have health insurance. I request my claims be submitted to my motor vehicle carrier. I understand I will be responsible for bills incurred by me in the event my PIP benefit exhausts or denies.

Patient/Guarantor Signature _____Date_____

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95 Soldiers Pass Rd, Suite B, Sedona, AZ 86336
Phone (928) 203-4844 Fax (928) 203-4497

CONSENT TO RELEASE MEDICAL RECORDS & INFORMATION

I, _____ , Printed Name,

authorize the following physicians, laboratories and hospitals to release my records including diagnosis, treatment, exams and reports pertaining to services rendered to me to Mary DeRose, D.C. at Choices Integrative Healthcare of Sedona. I acknowledge that such records may possibly contain information related to mental health problems, drug or alcohol use, sexually transmitted diseases or HIV/AIDS testing and treatment.

PLEASE PRINT THE NAMES (AND ADDRESSES IF OUTSIDE OF ARIZONA) FOR THE FOLLOWING:

Physicians	Hospitals	Laboratories
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

This consent will expire on _____ or sixty days after the date signed. I may revoke this consent at any time.

Patient Signature: _____Date of Birth:_____

Address: _____

_____

Witness Signature: _____Date:_____

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Confidential Patient Information

Name: _____ Date: _____

How many children do you have: _____
Occupation:_____

Do you have medical insurance: __Yes __No

What is your major complaint today :_____
_____

Other complaints_____

_____

Are these a result of: ___Auto Accident __Accident at Work ___Neither

How long have you had this condition:_____

What aggravates your condition: _____

Is this condition getting worse: __Yes __No __Constant __Comes and goes

Does this condition interfere with your __Work __Sleep __Daily Routine

Other _____

Please list previous diagnosis and treatments you have received for your present condition:
_____

Please list surgical operations: _____

Please list previous fracture/broken bones and the year: _____

_____

Please list hospitalizations:
_____

Please list all prescription and over the counter medications and supplements you are presently taking:_____
_____

How often do you see a dentist: ____every 6 months ___Yearly ___Toothache or emergency only

Please list any serious accidents, injuries and/or falls (auto, work, home. Leisure, other)
_____
_____

Do you wear orthotics, heal or sole lifts in your shoes: ___yes __no
Type_____

Family Health Information (Many health problems are a result of hereditary spinal weakness; thus information about your family members will give a better picture of your total health)

Relationship	Past and present health problems

Please answer the following five questions regarding your occupational situation. Please circle what apply.

Do you: Sit Stand Work Bench Desk Counter
Other:_____

Does your job involve: Lifting Bending Stooping Twisting Turning Carrying Walking Standing

If you sit, is your chair: Executive Steno Bench Stool Folding
Other:_____

What type of shoes do you wear to work:_____

What are your sedentary activities (i.e. TV, Reading, Cards, Sewing):
_____

What are your strenuous activities _____

_____

How do you grade your general stress level? None Minimal Moderate Great

Have you been to a chiropractor before? Yes No

Whom:_____

_____ _____

Patient Signature Date