Patient Policies

Thank you for choosing Active Health. We are committed to providing the highest quality of care for our patients. In order to do so, we need your assistance and acknowledgment of our policies.

Cancellations, No Shows, and Rescheduling Appointments

Life happens and we understand that. For your health and well-being it is very important that you attend all of your scheduled appointments. In the event you do have to cancel, we strongly encourage you to reschedule within 48 hours. If you wish to reschedule or cancel an appointment we require a minimum 24-hour advanced notice. Anything less will result in a $75 fee for the first incident and $100 fee for subsequent incidents. The fee will be collected at your next appointment. If no visit is scheduled, a bill will be mailed to you.

Insurance Coverage

We have verified your insurance coverage prior to your appointment and you were given an estimate of the total cost for your visit(s). Realize this is only an estimate. We rely on your insurance company to give us proper information but cannot guarantee accuracy. Charges can vary depending on the procedures completed. As a courtesy to you, we will bill your primary insurance company for covered charges. If your insurance requires pre-authorization and/or a referral for physical therapy, it is your responsibility to ensure that the referring physician or your PCP has obtained the necessary pre-authorization. If we do not have the proper authorization, or referral at the time of your visit, it may be necessary to reschedule your appointment, or you will be required to pay for your visit in full. In the event that we are paid for the service by your insurance company, you will be reimbursed for the visit, less any applicable copay, deductible, and non-covered charges.

Medicare Patients

Medicare covers 80% of the cost of your physical therapy after your yearly deductible has been met.
If you have a secondary insurance, we will file the remaining balance to your secondary insurance. If you do not have a secondary insurance or your secondary insurance does not cover all of your therapy, you will be responsible for the balance. Medicare has a yearly dollar value therapy “cap” (a maximum benefit amount) for out-patient physical therapy services. Once your Medicare benefits have been exhausted and you will have “pay out of your pocket” to continue your treatment.

Payments

We require that the co-payment, deductibles and non-covered charges will be collected at the time of service and that patient remits payment for any balance due to continue services. Failure to abide by this policy or if we do not receive payment within 30 days will result in the necessary action to collect payment. Active Health will contact you via phone or email regarding your delinquent account(s). I authorize Active Health and its agents, representatives, attorneys
(including collection agencies) to use automated telephone dialing equipment, artificial pre-recorded voice or text messages and personal calls and emails, in their effort to contact me for purposes of collecting any portion of my account which is past due. Any balance past due 90 days or more may be submitted to an attorney and/or agency for legal collection for which the undersigned agrees to be 100% responsible for all monthly service charges, interest, costs related to but not limited to all collection related expenses, attorney fees, court & filing fee’s. Returned checks, debit & credit charges made payable to this Facility for insufficient funds, stop payments or other reasons of non-payment will be assessed a $35.00 fee.

Collaborative Practice Arrangement

Active Health is a Collaborative Practice Arrangement. We are a group of health care professionals, including a chiropractor, physical therapist and a nurse practitioner, working together to coordinate and fulfill your needs. We believe this arrangement provides patients with treatment that is beneficial to patient well-being and improves patient health outcomes. Through this collaborative practice arrangement, our health care professionals participate in joint activities, such as quality improvement and coordination of care, in order to deliver comprehensive care that best meets the needs of our patients. You are receiving this notice because your information, including your medical, billing and other health information will be shared among the health care professionals participating in this arrangement for Treatment, Payment, Operations and other legal uses. The health care professionals participating in this collaborative practice arrangement may also bill you and/or your insurance carrier for the chiropractic services and the medical services separately. The health care professionals assisting you with your medical care may seek reimbursement for your medical treatment as a separate entity than the chiropractic health care professionals. Additionally, if you receive both chiropractic care and medical care during the same office visit, you and/or your insurance company may receive one bill for the chiropractic care and another bill for the medical care. You always retain the right to seek treatment from any other outside providers should you so choose and nothing contained herein is intended to limit your choice of providers.

Consent for Non-Covered Services

Unfortunately, your insurance does not pay for all of your healthcare costs. The services listed below are not considered "covered benefits" under your health insurance plan. The services are either considered not medically necessary, experimental/investigational, or simply non-covered by your health plan. The following non-reimbursable services are the responsibility of the patient.

Non-Covered Services:

EPAT (Extracorporeal Pulse Activation Technology) - $79.50
Hypervolt - $47.50
Acupuncture -
$49 for 5 needles
$79 for 6 + needles
Cupping - $15
Acupuncture & E-STIM - $139
NormaTec -
$15 for 15 minutes
$25 for 30 minutes/two regions
Trigger Point Injections -
$50 for 1-2 injections
$75 for 3 or more injections

I acknowledge and agree that part of my care is not a covered benefit of my health plan. I understand that Active Health will not bill my health insurance plan for these services. I acknowledge that I have been informed and understand that I will be financially responsible for this part of my treatment. By signing this document, I am agreeing to pay for this charge prior to such services being rendered.

_____ _____
Print Name of Patient Date

_____
Signature of Patient (if minor, parent or legal guardian must sign)

Patient Financial Responsibility Form

Thank you for choosing Active Health for your medical needs. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies. The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for treatment and care.

Insurance Information:

We are pleased to assist you by billing for our contracted insurers. However, the patient is required to provide us with the most correct and updated information about their insurance, and will be responsible for any charges incurred if the information provided is not correct or updated. Please be aware that your insurance policy is a contract between your and your insurance company. It is your responsibility to know the rules and regulations of your plan. Your account with this office is your responsibility whether or not your insurance company pays. We will do all we can to assist you with your healthcare claims. If we do not receive payment from your insurance company within 60 days from the date of service, the balance of the account will be your responsibility. A detailed receipt will be provided for all services paid. Patients are responsible for the payment of co-payments, co-insurance, deductibles, and all other procedures or treatment not covered by their insurance plan at the time of service.

Estimated Self-Pay Rates:

Initial Appointments:

- $494.50 with Dr. Lipp
- $284.16 with Dr. Brown

Follow-Up Appointments:

- $189.50 with Dr. Lipp
- $136.50 with Dr. Brown or treating provider

Re-Exam/New Injury Appointments:

- $284.50 with Dr. Lipp
- $204.93 with Dr. Brown

Strength Appointments:

- $113.45 with Hypervolt
- $136.50 with EPAT

Initial exams will be performed for all new patients. Initial exams will be performed for patients who have not been seen in over three years. Re-exams will be performed for all existing patients who have not been seen in three months, present with a new condition, or as deemed medically necessary by the doctor.

Patient Financial Responsibility Form

Please read each paragraph carefully, check the corresponding box, and initial to elect to utilize your health insurance plan or agree to the self-pay rates.

☐ **Check here if you agree to the self-pay rates for services rendered and elect to not use available medical insurance.**

I understand that the medical services provided by Active Health will not be billed to my health insurance plan and I agree to not bill my insurance company for these services. Additional services may be recommended to me after examination. I understand that these are estimated fees and are subject to vary. I understand that I am personally paying for the medical services/procedures at a discounted time of service rate, because I agree with my doctor's recommendation and treatment for my condition.

Patient Initials: _____

☐ **Check here if you elect to use available medical insurance.**

I understand that it is my own responsibility to know my insurance benefits, including whether Active Health is a contracted provider with my insurance company, my covered benefits and any exclusions in my insurance policy, and if there are any pre-authorization/referral requirements of my insurance company. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full. Additional services may be recommended to me after examination. I understand that these are estimated fees and are subject to vary. I understand that I am responsible for the payment of any applicable co-payments, deductibles, co-insurances, and non-covered charges at the time of service.

Patient Initials: _____

I have read, understand, and agree to the provisions of this Patient Financial Responsibility Form, which explains my patient's financial responsibility.

_____ _____

Signature of Patient/Guardian **Date**

Health Care Privacy Notice - Informed Consent - Assignment of Benefits - Authorization & Lien

This office is committed to providing patients with quality health care services delivered with dignity, respect and concern. Fulfilling this commitment requires the efforts of the doctors, therapists, staff and patient working together as a team to obtain the maximum results. Patient satisfaction is a vital interest to our staff. This Facility is required by law to abide by the terms of this Health Care Privacy Notice, Patient Bill of Rights and Informed Consent as well as other applicable federal and state laws governing privacy practices in health care. Our Facility may change and/or modify the terms of this Notice at anytime without additional notice to you except to publicly post in our Facility and/or make available to patients any updated notices. Photocopy of this Notice is available to you upon request. The term Facility refers to this office or clinic. The term Provider refers to doctors and/or licensed professionals of this Facility. Our Facility & staff are committed to maintaining the privacy of your protected health information (PHI). PHI is information about you, including demographic information that may identify you and that may be related to your present, future and past physical or mental health or condition and the care and treatment you receive from our practice. This Notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please read this Notice and direct questions, misunderstandings or concern to the Compliance Officer of this Facility. Our Facility may use & disclose your PHI for health care delivery purposes. Your PHI may be used and/or disclosed without your written authorization by the doctors and staff of this Facility for the purposes of your care and treatment; paying your health care bills; and to support the operations of this practice. Your doctor and the staff will take all reasonable measures to maintain the confidentiality of your PHI. The Privacy Rule allows you the right to review and receive copies of your health care records as it relates to your health care. The request must in writing, allowing your provider 30 days to respond. Your provider may deny your request if it will cause harm to you or to another person. Your provider may charge a copy fee, which will be in compliance with State law. Your provider will comply with any reasonable request to have confidential communication by alternative means or at an alternative location if not doing so endangers you. You may request to have an amendment placed in your record if you disagree with anything in your record. This does not mean that anything will be removed or changed and the provider has the right to respond with a rebuttal statement if he/she feels it is necessary. You may revoke authorization, in writing, at any time, except in the event that the provider has acted as indicated in the doctor's Authorization Notice. You have the right to file a written complaint with our Compliance Officer if you believe that any of your privacy rights have been violated. You can obtain a complaint form from the Compliance Officer and/or the Office of the Civil Rights. All complaints must be filed within 180 days of when you knew or should have known that the violation occurred. The Privacy Law prohibits our Facility from taking any retaliatory actions against anyone who files a complaint. A more detailed, updated & comprehensive Health Care Privacy Notice is available for your review in this Facility. I understand that this Facility, its doctors & staff are accepting my case based on examination findings & believe the outlined treatment should produce change and/or improvement. However as with any diagnostic test, procedure, examination or doctors care, a guarantee of improvement or complete recovery cannot and has not been made and it is even possible that no change will occur. Our Facility further wants you to understand your Patient Bill of Rights, options for care and risks of treatments rendered by us. In the practice of medicine, surgery, chiropractic, spinal or joint manipulations/adjustments, podiatry, psychological counseling, massage, physical, occupation, speech & respiratory therapy there are some risks. These risks may include but are not limited to soreness, dizziness, fractures or joint injury, disk injuries, strokes, heart attacks, dislocations, sprains/strains, drug interactions, procedural complications, reactions and/or other injuries which maybe short or long term or side effects which cannot be pre-determined.

I do not expect the doctor/provider to be able to anticipate and explain all risks and/or complications, and I wish to rely on the doctor/provider to exercise judgment during the course of the procedure(s) which the doctor/provider feels at the time is in my best interest. As our patient you can voluntarily stop care or ask questions about reasonable alternatives to the procedures we will recommend including but not limited to rest,, home applications of therapy, prescription or over-the-counter medications, exercises and/or referral to a medical/surgical specialist. In addition, because psycho-social, spiritual, and cultural values affect a patient's response to care, patients are allowed to express and follow spiritual beliefs and cultural practices that do not harm others or interfere with the planned course of treatment. Patients have the right to refuse treatment, but must be aware of the probable consequences of refusing treatment and/or failing to cooperate with the prescribed treatment. Should you refuse and/or fail to comply with prescribed treatment your provider will discuss specific consequences with you. Therefore I give my full consent to the doctor/provider to render treatment on me or the minor for whom I am legally responsible by a health care provider of this Facility. I, the assignee, being the patient or legal guardian for said minor listed below, do hereby irrevocably authorize, direct, assign and give a full lien to the office named above and listed below, hereinafter referred to as the "Facility" against any & all insurance benefits, proceeds of any settlement, judgment or verdict which may be paid to the undersigned as a result of the injuries or illness for which I have been treated by the Facility. I, the assignee further authorizes any and all insurance company, attorney and any & all third party payer to pay directly to the Facility all sums of money due them for any & all services rendered to me or minor by whom I am responsible for by reason of accident, illness and by any & all reason of any other bills that are due or may become due, and to withhold such sums from any health & accident, workers compensation and or including all insurance or third party benefits. Assignee agrees that this Facility & staff may deliver medical records, consultations, depositions and/or court appearances which must be paid in full in advance and authorizes this Facility to release any information pertinent to said health care to any insurance company, adjuster, attorney or legal service bureau to facilitate collections under the tems of this document. Assignee grants the Facility a full power of attorney to endorse &/or sign my name on any & all checks for payment of any indebtedness owed this office & assignee.

By my signature below I acknowledge that I have read or have had read to me and have received a photocopy upon my request of this document including the Health Care Privacy Notice, Facility terms & conditions, credit policies and Informed Consent and fully understand and have had all of my questions answered to my satisfaction. A photocopy of this document shall be considered as effective and valid as an original. I have made my decision voluntarily and freely to submit for healthcare services in this facility.

_____ _____

Print Name of Patient Date

_____

Signature of Patient (if minor, parent or legal guardian must sign)

Cancellation / No-Show Policy

We strongly stress the importance of keeping all scheduled appointments to achieve your personal physical goals. We understand life happens and you may need to miss a scheduled appointment. However, please be considerate and provide adequate notice if you cannot make your scheduled appointment. Helping each and every patient get the results they need is very important to Active Health. Our schedule is very full and certain time slots are not always available to patients who need them. For this reason we have a 24-hour cancellation policy in effect. If for any reason you cannot make a scheduled appointment, we require 24 hours notice. When you call we will assist you in rescheduling this appointment because your results are our only goal.

We strive to provide you the best, personalized care available. To make this possible we adhere to a set of very strict guidelines. **Please read them carefully and initial all the boxes to better help us help you.**

☐ As experts, we know that you will not get better if you do not attend your appointment. When you call to cancel, we expect that you will have other times available so we can reschedule you right away.

☐ We require that you cancel any appointment that you cannot make with no less than 24 hour notice. We will get you rescheduled at that time. If you know you cannot make your appointment and it is after our business hours, please call and leave a message as it is better than calling the morning of your appointment.

☐ If you wish to reschedule or cancel an appointment we require a minimum 24-hour advanced notice. Anything less will result in a **$75 fee for the first incident** and **$100 fee for subsequent incidents.** The fee will be collected at your next appointment. If no visit is scheduled, a bill will be mailed to you.

☐ If you are running late for your scheduled appointment we expect that you will call us immediately. Being late by more than 15 minutes may require you to either reschedule or wait for the next available opening. Please understand our commitment to outstanding service extends to all of our patients.

☐ Please also be aware that if you are late for your appointment, you are missing the time that we have specifically scheduled for your care and we cannot guarantee that we will be able to provide you with your full treatment as we have reserved the appointment time following yours for someone else. Chronically late patients will be asked to change their appointment times.

☐ No shows are bad and will not be tolerated. If you fail to show up for an appointment without notice, all future appointments will be removed and a $100 fee will be charged to your account. After missing two appointments without notice, you may be placed on a same day scheduling policy for your treatments, which would not allow you to schedule any appointments in advance.

Patient Electronic Communications Consent

Active Health offers patients the opportunity to communicate occasionally using electronic means email, voicemail, and standard SMS messaging. Electronic communication is a widely accepted form of communication. While it cannot replace personal encounters between you and your health care provider, it can be a convenient way to exchange information.

I understand and agree that:

- I understand that under the HIPAA Privacy Rule, patients have the right to request that their provider communicate with them via their preferred means, and providers are obligated to accommodate these requests, if reasonable. I understand I can revoke this consent at any time by contacting Active Health. I understand this consent will remain in effect until revoked in writing.
- I understand that email, voicemail, and standard SMS messaging are not confidential methods of communication and may be insecure. I further understand that, because of this, there is a risk that email, voicemail, and standard SMS messaging regarding my medical care might be intercepted and read by a third party. Therefore, you are agreeing to accept the risk that your protected health information may be intercepted by persons not authorized to receive such information when you consent to communicating with us through phone, voicemail, email or standard SMS messaging. Active Health will not be responsible for any privacy or security breaches that may occur through voicemail, email or SMS messaging communications that you have consented to.
- I understand that I am responsible for notifying Active Health when my contact information changes.
- I understand that email communication should not be used for emergencies or for communicating time sensitive information. In the event of a medical emergency I should contact 911 or go to the nearest Emergency Department.

I hereby consent and state my preference to have my physician, Active Health, and other staff at Active Health communicate with me by email, voicemail, or standard SMS messaging regarding various aspects of my medical care, which may include, but shall not be limited to, test results, appointments, and billing.

_____ _____

Signature of Patient/Guardian **Date**

Release of Protected Health Information

Name:_____

☐ I give permission for Active Health to leave messages by voicemail, email, standard SMS messaging regarding my appointments or billing concerns.

☐ I consent to receiving appointment reminders by email, phone/voicemail, standard SMS messaging from Active Health.

☐ I give Active Health permission to discuss my physical therapy condition and plan of care with the following individuals:

Name:	Relationship:
_____	_____
_____	_____
_____	_____

☐ No, Active Health may not discuss my condition or plan of care with any individual except myself

Signature: _____ Date: _____

Opt-In Consent Form

Your health care is important to us. In order to provide you with the best possible care, we occasionally send convenient text messages to our patients about their health care and the products and services we offer.

You are currently set to receive text messages for appointment reminders and information about your healthcare treatment. The Telephone Consumer Protection Act's (TCPA) health care exemption allows healthcare covered entities to deliver health-related messages to patients and consumers as long as they comply with HIPAA and certain conditions.

I agree to receive recurring telephone calls and/or SMS or MMS text messages for marketing purposes at the phone number provided, including but not limited to calls or texts sent using an automatic telephone dialing system or an artificial or prerecorded voice. I am authorized to consent to receive text messages sent to the phone number provided. I understand that I may revoke consent at any time. I understand that consent is not a condition of purchase. Message and data rates may apply.

Cell Phone Number: _____

Email: _____

Signature of Patient/Guardian: _____

Date: _____

Todays Date:

Patient Information

Name _____ Date of Birth _____ Sex ◯M ◯F

Street Address _____ City/State _____ Zip _____

Social Security # _____ Status ◯Single ◯Married ◯Other

Cell Phone _____ Home Phone _____

Work Phone _____

Best Number to Call ◯Cell ◯Home ◯Work

Email Address _____ ☐No Email ☐Decline Email

Appointment Reminder Contact Method? ☐ Text ☐ Email ☐ No Appointment Reminder

Emergency Contact Information

Contact Name _____ Phone _____ Relationship _____

Employment Status FT PT None Retired Student

Employer _____ Occupation _____

Primary Care Doctor _____ Referring Provider (if different) _____

May we send your doctor your physical therapy evaluation? ◯ Yes ◯ No

How did you hear about our office?

◯My Doctor _____ ◯Family/Friend_____

◯Internet ◯Walk/Drive by ◯Other_____

Insurance Information

Primary Insurance

Insurance/Plan _____

Policy ID # _____ Group # _____

Are you the policy holder? ◯Yes ◯No If no, please provide policy holder information.

Policy Holder Name _____ Date of Birth _____ Relationship to Patient _____

Secondary Insurance

Insurance/Plan _____

Policy ID # _____ Group # _____

Are you the policy holder? ◯Yes ◯No If no, please provide policy holder information.

Policy Holder Name _____ Date of Birth _____ Relationship to Patient _____

Medical History

Patient Name _____ Height ____ ft ____ in Weight _____ lbs

Primary Concern or Symptoms _____

How did this injury/exacerbation occur? _____

Where did this injury occur? ◯ Home ◯ Work ◯ Automobile ◯ Sports

Approximate Date of Onset _____

Are your symptoms currently ◯ Getting Better ◯ Same ◯ Constant ◯ Worse

What is your current pain level, on a scale of 0-10? (0 - No Pain, 10 - Worst Pain)

0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯

Have you had any of the following? ☐ X-Ray ☐ MRI ☐ CT Scan

If Yes, results_____

Have you seen another doctor for this problem? ☐ Yes ☐ No If Yes, who _____

Have you had this problem or symptoms in the past? ☐ Yes ☐ No

Have you been hospitalized for this condition? ☐ Yes ☐ No If Yes, date _____

Have you had surgery for this condition? ☐ Yes ☐ No If Yes, date _____

If Yes, surgery type _____

Have you had any other treatments for this? ☐ Yes ☐ No If Yes, explain_____

Please list any medications you are taking (prescription, over the counter and vitamin):

_____

Please list any allergies (drug, chemical, latex, iodine) _____

Do you consume alcohol? ☐ Yes ☐ No If Yes, frequency _____

Do you use tobacco? ☐ Yes ☐ No If Yes, frequency_____

Please check each condition you have been told you have/had?

☐ Tuberculosis	☐ Diabetes	☐ Heart Condition
☐ Cancer	☐ Hepatitis	☐ Epilepsy
☐ Arthritis	☐ Stroke	☐ Respiratory Problems
☐ Pacemaker	☐ Dementia	☐ High Blood Pressure
☐ Osteoporosis	☐ Osteopenia	☐ Liver Disease
☐ Fibromyalgia	☐ Diabetes	☐ Incontinence

Do you have any other conditions ☐ Yes ☐ No If Yes, please explain_____

_____

Are you interested in a complimentary consultation to learn how Regenerative Medicine can help you?

◯ Yes ◯ No

Are you interested in custom orthotics?

◯ Yes ◯ No

Current Condition

Primary Complaint _____

What increases your pain? _____

What decreases your pain? _____

Describe when your symptoms occur (check all that apply)

☐ Constant ☐ Intermittent ☐ Chronic ☐ With Activity ☐ Upon Waking

Describe your pain (check all that apply)

☐ Sharp ☐ Stabbing ☐ Aching ☐ Burning

☐ Numbness ☐ Pins & Needles

What activities are you restricted from by your condition? (check all that apply)

☐ Dressing ☐ Walking ☐ Pushing ☐ Bathing

☐ Lifting ☐ Pulling ☐ Eating ☐ Work

☐ School ☐ Driving ☐ Standing ☐ Sleeping

☐ Housewotk ☐ Lying Down ☐ Sport ☐ Sitting

What do you want to achieve from having therapy? (check all that apply)

☐ Improve home activities ☐ Improve leisure/sport activities ☐ Improve self care activities

☐ Improve mobility/walking activities ☐ Improve health/wellness ☐ Return to work

Please answer the following questions required by your insurance company.

Do you use any assistive devices? ◯ Yes ◯ No If Yes, explain _____

How many story(s) is your home? ☐ 1 ☐ 2 ☐ 3 ☐ Other _____

How many step(s) or stair(s) does your home have? _____

Does your house have handrail(s)? ☐ N/A ☐ Left ☐ Right ☐ Both Sides

Please list anyone that lives in the same home as you. _____

What is your goal for therapy?

_____