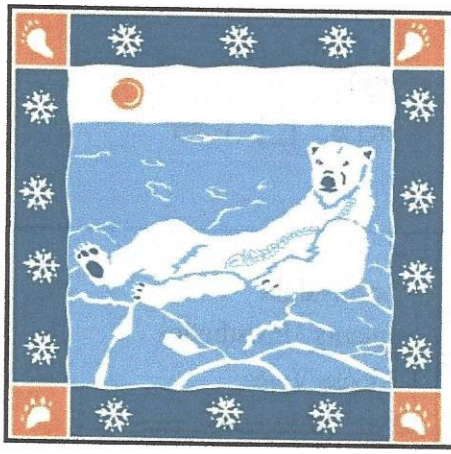


Arctic Chiropractic

Juneau

2243 Jordan ave, Juneau AK 99801
Phone: (907) 790-3371 Fax: (907)790-2102

Initial Intake Form for Massage Therapy

Date: _____

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Occupation: _____ Phone #: _____

Primary Care Provider: _____ Phone: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact: _____ Relationship: _____

Phone (home): _____ Work: _____ Cell/Pager: _____

Referred by: _____

Current Health:

Have you received massage therapy before? _____ Yes _____ No Frequency: _____

Type of Massage received? _____ Deep Tissue _____ Swedish _____ Therapeutic _____ Sports _____ Other

Reason for today's visit: _____

Desired result of today's session: _____

Have you received treatment for this before? _____ Yes _____ No

Explain: _____

_____

List Activities Affected: _____

Are you currently under the care of a physician? _____ Yes _____ No

Current Medications / Herbs: _____

Stress Reduction / Relaxation / Exercise Activities: _____

Please indicate your consumption of the following on a scale of 0-5 (5 being heavy):

☐ Salt ☐ Sugar ☐ Caffeine ☐ Tobacco ☐ Alcohol ☐ Exercise ☐ Water

Do you have a History of any of the following:

☐ Accident
☐ Neck Pain
☐ Whiplash
☐ Headaches
☐ Dizziness
☐ Anxiety
☐ Depression
☐ Disc Problems
☐ Broken Bones
☐ Arthritis / Bursitis/Gout
☐ Rash
☐ Hepatitis
☐ Mid Back Pain
☐ Low Back Pain
☐ Joint Ache
☐ Decreased Range of Motion
☐ Sprains
☐ Epilepsy / Seizures
☐ Abdominal Pain
☐ Nervous Tension
☐ Surgery
☐ Wear Contacts
☐ Edema
☐ Fainting
☐ Fibromyalgia
☐ Implants / Prosthetics
☐ Varicose Veins
☐ High Blood Pressure
☐ Diabetes
☐ Heart Attack
☐ Low Blood Pressure
☐ Stroke
☐ Heart Conditions
☐ Cancer
☐ Colitis
☐ HIV/AIDS
☐ Recent Injury or Trauma

Explain: _____

_____

Allergies or Sensitivities

☐ Oils ☐ Lotions ☐ Scents ☐ Detergents ☐ Foods

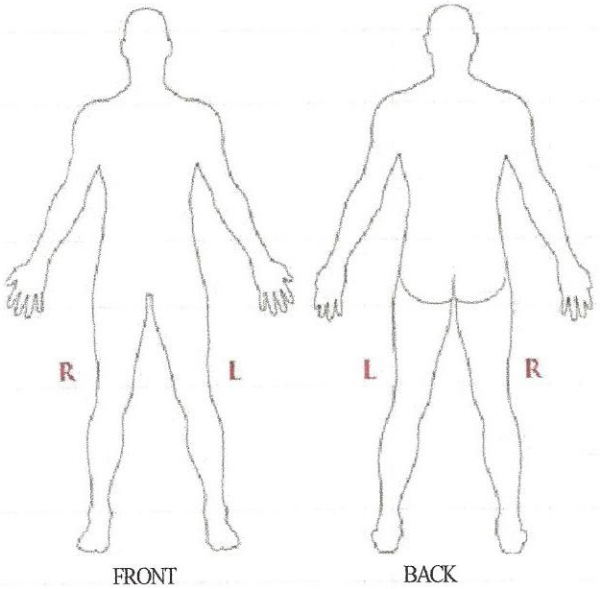
☐ Other: _____

Do you have any of the following today?

☐ Pregnancy: If so, How far along are you? _____ Due Date: _____

☐ Inflammation ☐ Skin Rash ☐ Headache ☐ Sunburn / Poison Ivy
☐ Severe Pain ☐ Open Cuts / Bruises / Burns ☐ Cold / Flu

Please indicate with an (X) the places you are feeling discomfort



Consent for Care:

It is my choice to receive Massage Therapy. I understand the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success or effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination, or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status.

Signature: _____

Date: _____

Arctic Chiropractic Juneau
Massage Therapy Policies
Please, read carefully!

*Revised **Jan 1, 2014***

At ***Arctic Chiropractic Juneau***, as a part of our commitment to provide the best service to our patients and out of consideration for our therapists' time, we have adopted the following policies:

ARRIVAL

Please, arrive for your appointment at least *5-10 minutes prior* to the scheduled starting time. This allows you the time to fill out the appropriate forms (if you're a new patient you'll need additional time), change, use the bathroom and prepare for the session. All massages have a set schedule and early arrival allows for a relaxed and unhurried experience.

LATE ARRIVAL

In fairness to the next patient, please arrive on time. ***Sessions begin and end at scheduled times. Sessions begun late due to the patient late arrival, end at the appointed time. If you are running just a*** few minutes late, we will continue with your appointment, but please understand that you will only receive massage for the time remaining in your appointment.

We encourage you to reschedule your appointment for later date if you're sick.

If late arrival is inevitable, your service(s)will have to be shortened in order to keep on schedule.

NO SHOW POLICY and CANCELLATIONS

Patients who fail to show for appointments or fail to give at least **24 hours prior notice** will be charged **$40** for the unused slot. If a patient cancels an appointment or doesn't show for the appointment multiple times (3 or more) we will be unable to schedule any appointments for him/her in the future.

The ONLY exception to these policies will be for medical emergencies, death in the family, or severe weather.

CONFIDENTIALITY

Everything discussed during the session will be kept confidential except when subpoenaed by a court of law.

Patient details would not be revealed, unless the patient has given written permission to do so. We will not confirm nor disclose the fact that a specific person is our patient, unless we have permission and the written consent of the client to do so.

SEXUAL APPROPRIATENESS

Sexual behavior by the patient toward the therapist or by the therapist toward the patient is unethical, inappropriate and unacceptable. Sexual harassment is not tolerated. If the therapist's or patient's safety feels compromised, the session will be stopped immediately.

WHAT TO EXPECT

You may dress however you wish, but if you would like to receive a massage following a workout, please shower before your massage. You should feel free to remove as much or as little of your clothing as you wish. Patient is always fully draped, meaning that only the part of his/her body where the massage therapist is working at that particular moment will be exposed.

Usually there will be soft music playing in the room, but we will gladly change the music or work in silence if that's what the patient prefers. Please remember that *only you can feel what is going on inside your own body*, and that you should feel free to give the massage therapist feedback about the amount of pressure, temperature in the room, general comfort, or if anything at all is painful or uncomfortable.

We want you to have the best experience and we'd appreciate if you could ***take off all jewelry and watches, turn off your cell phone, avoid wearing heavy perfumes/colognes, refrain from smoking 1-2h prior your appointment and avoid consuming alcohol before and after the appointment.***

I have read Arctic Chiropractic's massage therapy policies and I agree to comply with them.

Patient name:_____

Patient Signature:_____ **Date:**_____

Parent/Guardian name:_____

Parent/Guardian signature:_____ **Date:**_____

Medical Massage Therapy

Your medical massage therapy benefit is part of your physical therapy component of your insurance policy. This means that there are stipulations for using your massage therapy benefit.

First, there needs to be a medical necessity for you to use your massage therapy benefit. You must see a doctor who will determine if there is a medical necessity.

Massage therapy may be considered medically necessary when performed to meet the functional needs of a patient who suffers from physical impairment, functional limitation or disability due to disease, trauma, congenital anomalies, or prior therapeutic intervention. The patient must also have a reasonable expectation of achieving measurable improvement in a reasonable and predictable period of time based on specific diagnosis-related treatment/therapy.

If there is a medical necessity for your condition, your doctor must write a prescription for you to have massage therapy. Insurance will not cover a massage without a prescription. This is why you must first see a doctor! The prescription includes treatment frequency and duration determined by the doctor.

Second, you must continue to see your doctor throughout your care, so that he may be able to document your progress and improvement. The doctor may need to make changes to your prescription depending on your progress or lack thereof.

Medical massage therapy is not an open ended benefit. It must be monitored closely to insure it is still medically necessary and has not become maintenance care. If there is no progress being made or if you have reached your treatment goals, massage therapy may no longer be medically necessary.

Your insurance does NOT cover maintenance massages. Maintenance care is defined by your insurance company as:

A maintenance program consists of activities that preserve the patient's present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of the Plan of Care have been achieved, or when no additional functional progress is apparent or expected to occur. This may apply to patients with chronic and stable conditions where skilled supervision is no longer required and clinical improvement is not expected. Massage therapy services that enhance performance beyond what is needed to perform routine functional tasks is not a covered benefit.

Please sign below to acknowledge you have read, understand, and agree to follow your treatment care plan for medical massage therapy by:

- Seeing the Doctor FIRST to determine genuine medical condition that affects quality of life including loss of function/pain.
- Seeing the Doctor throughout your treatment so they may document and monitor your progress; and re-evaluate your treatment care plan as needed.
- Allowing the Doctor to set the parameters (including duration and frequency) of your treatment care plan.

Patient name _____

Signature _____ Date _____

Arctic Chiropractic Juneau LLC

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

USES AND DISCLOSERS OF PROTECTED HEALTH INFORMATION THAT WE MAY MAKE WITHOUT YOUR AUTHORIZATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, support the operation of the physician's practice and any other use required by law.

- **To contact you** - Your information may be used to contact you to remind you about appointments, inform you about treatment options or advise you about other health-related benefits and services.
- **Treatment** – Your information may be shared with any healthcare provider who is providing you with health care services. This includes coordinating your care with other health care providers and providing referrals to other health care providers. Examples of healthcare providers who may need your information to treat you include your doctor, pharmacist, nurse and other providers such as physical therapists, massage therapists, home healthcare providers and X-ray technicians. We may share your PHI electronically with your healthcare providers to make sure they have your information as quickly as possible to treat you.
- **Payment** – In order to obtain payment for your health care services, we may have to provide your PHI to the party responsible for paying. This may include Medicare, Medicaid or your insurance company. Your insurance company may need information about activities such as your eligibility of coverage, reviewing the medical necessity of the health care services provided to you or providing approval for specific services.
- **Healthcare Operations** - We may use or disclose, as needed, your PHI in order to support the business activities of our physician's practice. These activities include, but are not limited to quality assessment activities, employee review activities, training of medical students, licensing and conducting or arranging for other business activities. For example, we may disclose your PHI to medical school students that see patients at our office. In addition, we may use a sign in sheet at the front desk where you will be asked to sign your name and/or indicate your physician, as well as the time you arrived and left our office. We may also call you by name in the waiting room, when your physician is ready to see you. We may share your PHI with third parties who perform services such as transcription or billing. In those cases, we have written agreements with the third parties that they will not use or disclose your PHI except if permitted by law. We may also use your information (name, address, date of birth, department of service, treating physician, dates of treatment, outcome) for our fundraising activities.

OTHER USES AND DISCLOSURES THAT WE MAY MAKE WITHOUT YOUR AUTHORIZATION

There's a number of ways that your PHI may be used or disclosed without your authorization. Generally, these uses and disclosures are either required by law or for public health and safety purposes.

- When required by law;
- Public Health issues;
- Health oversight;
- Legal proceedings;
- Abuse & Neglect;
- Law Enforcement;
- Preventing a serious threat to the health and safety of a person or of the public;
- Coroners, Funeral Directors and Organ Donation;
- Research;
- Military Activity and National Security;
- Worker's Compensation

Please, retain for your records

- Inmates/arrestees;
- Disaster relief;

Other permitted and required uses and disclosures will be made only with your written authorization. You may revoke an authorization in writing at any time except to extent that your physician or the physician's practice has taken an action in reliance on the authorization.

YOUR RIGHTS

- **Access to your PHI** – You have the right to receive a copy of your health information that we maintain, with some limited exceptions. You may request access to your information in writing, and you may request a copy of your information in electronic format. We reserve the right to charge a reasonable fee for the cost pf producing and providing your health information. You have the right to request that your health information be sent to any person or entity, such as another doctor, caregiver or online personal health record.

- **You have the right to request a restriction of your PHI** - This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or health care operations. You may also request that nay part of your PHI not be disclosed to family members or friends who may be involved in your care for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If a physician believes that it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have to use another healthcare professional.

- **Confidential communications** – We will accommodate reasonable requests to communicate with you about your health information by different methods or alternative locations. For example, if you are covered on a health plan but are not the subscriber, and would like your health information sent to a different address than the one of the subscriber, we can usually do that for you.

- **Breach Notification** – You have the right to receive notification of breaches of your health information as required by law.

- **You may have the right to have your physician amend your PHI** - If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

- **You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI** - We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

QUESTIONS AND COMPLAINTS

If you have any questions or are concerned that any of your privacy rights have been violated, please contact the Secretary of Health and Human Services at:

Office of Civil Rights – AK, WA, OR, MT
U.S.Department of Health and Human Services
2201 Sixth Avenue – M/S: RX-11
Seattle, WA 98121-1831

CHANGES TO OUR PRIVACY POLICY

We reserve the right to change the terms of our Notice at any time. New Notice provisions will be effective for all PHI that we maintain. You may view a copy of our most current Notice on our website at www.arcticchiropracticjuneau.com, in the lobby at our office, or request a current copy from the medical records department or privacy officer at any time.

We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main office number.

Revised July 14, 2014

Please, retain for your records

HIPAA Consent Form

HIPAA – Notice of Privacy Practices

HIPAA is a federal law developed to provide a standard for the protection of your health information. The purpose of the Notice of Privacy Practice is to explain how Arctic Chiropractic Juneau LLC may use or disclose your health information. The Notice also explains the rights that you are guaranteed under HIPAA regulations.

Though Arctic Chiropractic Juneau LLC has always taken great care to protect the integrity and confidentiality of your health information, we are now required by the HIPAA Privacy Rule to distribute the notice to you and obtain acknowledgement that you have received the notice.

Signing below indicates that you have received the Notice of Privacy Practice. If you have any questions, please contact our HIPAA Compliance Officer below:

Temenuga Chavis
2243 Jordan Ave
Juneau, AK 99801

I hereby acknowledge that I have received a copy of Arctic Chiropractic Juneau's Notice of Privacy Practices.

_____ _____

Signature of Patient/ Guardian (if Guardian, please provide relationship to patient) *Date*

I, _____ **give permission to Arctic Chiropractic Juneau LLC to discuss the following medical information about me (check all boxes that apply):**

☐ Scheduling/Appointment information

☐ Medical information, including my symptoms, diagnosis, medications and treatment plan

☐ Billing and Payment information

Arctic Chiropractic Juneau has my permission to discuss this information with:

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Consent to Bill Insurance Plan(s)

By my signature below, I authorize Arctic Chiropractic Juneau LLC to bill my insurance company for the medical services provided to me. I authorize payment directly to my doctor and I permit this form to be used as "Signature On File" for all my insurance submissions. I understand that in order to obtain payment, my doctor may share exchange health information which may include diagnosis, service dates, types of services and other information that is necessary to process my claims. I understand that if payment is made directly to me for services provided by Arctic Chiropractic Juneau LLC, I am responsible for immediately sending such payments to the clinic. I am responsible to notify Arctic Chiropractic Juneau LLC of any changes in my health insurance coverage, as well as any denial information. I understand that I AM RESPONSIBLE for payments to Arctic Chiropractic Juneau LLC for charges regardless of my insurance coverage. I also understand that in the event my insurance company denies payment, I am responsible for the balance in full. I am aware that I am responsible for any co-payments and/or yearly deductible as specified under my insurance contract.

_____ _____

Signature of Patient/ Guardian (if Guardian, please provide relationship to patient) *Date*

Arctic Chiropractic Juneau

Financial Agreement Policy

We want to thank you for choosing Arctic Chiropractic Juneau as your health care provider. Our staff is dedicated to providing outstanding medical care to our patients. We do our best to be helpful and informative in the area of financial obligation. Feel free to let us know if you ever have any questions or concerns about this policy, we'd be glad to answer any questions. Please, read our financial agreement policy and let us know which option would be best for you.

Patients Without Insurance

If you do not have insurance, we expect payment in full at the time of service. For your convenience we accept cash, check, Visa, MasterCard, Discover, American Express and CareCredit. You may also choose to leave your signature and credit card on file; with your authorization, we will charge your card monthly for the balance on your account.

Patients With Insurance

Due to the fact that insurance plans differ and can be sometimes confusing, we will do our best to assist you. We will prepare your insurance claims for you and send them to your insurance. We will also bill your secondary insurance if you have one. We always make sure we re-submit any claims that haven't been processed and do our best to figure out why a claim or a service was denied/unpaid. Our goal is to make sure your claims are processed and paid without any hassle or problems. In order for us to do so, please inform us of any changes in your name, address, insurance. We will let you know if you need to contact your insurance company in order for claims to be processed, sometimes this is needed as they periodically they need to update information about subscribers or simply have some questions before they can process your claim. Under this agreement, you are responsible for paying your co-pays, non-covered portions, or any annual deductible that has not been satisfied yet. For your convenience we accept cash, check, Visa, MasterCard, Discover, American Express and CareCredit. You may also choose to leave your signature and credit card on file; with your authorization, we will charge your card monthly for the balance on your account. ***Please, note that you are responsible to know and understand your insurance policy and you are responsible to pay Arctic Chiropractic Juneau LLC your account balance if your insurance doesn't pay.***

A word about our Fees

Our charges are based on Alaska Workers' Compensation Fee Schedule (for more information go to *http://labor.state.ak.us/wc*) and are within the "reasonable and customary" range by most insurance plans; however, some insurance companies have determined their own "payment schedule", which sometimes could be more or less than our fees. Please, note that some services may be considered as non-covered under the policy limitations.

Please, check one of the following:

With Insurance:

☐ I prefer that you bill my insurance company, I will pay my co-pay and/or my office visit charge on each visit.

☐ I prefer that you bill my insurance and charge my credit card monthly for the balance on my account.

Without Insurance:

☐ I prefer to pay if full on each visit.

☐ I prefer you to charge my credit card monthly for the balance on my account.

Patient Name _____ Signature _____ Date _____

Print Name if not signed by patient: _____

Revised 9/2014