ARVADA SPORT and SPINE GROUP

12189 W 64th Ave Ste 102
Arvada, CO 80004
Office: 303-424-9549
Fax: 303-424-7389

Patient Financial Responsibility Statement

Patient Information

Patient Name _____
Date of Birth _____
SSN _____
Address _____
Phone Number _____

Patient Financial Responsibility Statement

Thank you for choosing us as your health care provider. We are committed to providing quality health care. Please understand that payment for your bill is considered part of your care plan. We ask that you read and sign this Financial Policy prior to any treatment. Please let us know if you have any questions. We will do a complimentary insurance verification check. It is the patient's responsibility to supply all current insurance cards and update us immediately of any change to your insurance prior to your appointment. We will ask you for a copy of your driver's license or other picture identification issued from the DMV for identity verification.

I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance for my visits. This includes any service or visit given by our healthcare providers.
I understand and agree it is my responsibility and not the responsibility of the provider or the providers' staff to know if my insurance will pay for any services I receive, regardless of what anyone may have told me.
I understand and agree it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out-of-network amounts, usual and customary limits, or any other type of benefit limitations for the services I receive. If I have an insurance plan with a deductible or co-insurance responsibility, I agree to keep a credit or debit card on file. *After 30 days of receiving my first statement, I agree to have my card on file charged automatically for my patient-responsible amount if I do not submit payment.* For services covered by your insurance we do not balance bill as required by law. If we are unable to charge your credit card on file for the balance and we are unable to collect payment from you after 60 days of your first statement, your account will be turned over to a collections agency where an additional fee equal to 30% of the amount owed will be added to cover the collections agency fees.
I understand that I am responsible for all costs of collection if my account is turned over to the Collection Agency including attorney fees, collection fees of 30% and court costs. I understand that any unpaid balance will be assessed interest rate at the rate of 18.00% (1.5% monthly). Insurance claims are filed as a courtesy, but it is my responsibility to see that the claims are paid. I fully understand that I am responsible for payment of fees not covered by insurance. I also assign all benefits to Provider. I authorize the submission of claims without obtaining my signature on each claim submitted. I give my authorization and consent for treatment after having a full explanation of proposed treatment, alternatives, and risks by my doctor. I have been advised of my privacy rights as provided by the Healthcare Information Portability and Accountability Act of 1996. I hereby authorize Arvada Sport and Spine Group and its employees, agents, and assignees to contact me via e-mail, text messaging and to my cellular devices using automated telephone dialing systems. Arvada Sport and Spine Group accepts cash, checks, VISA, MasterCard, and Discover. A $25 fee will be assessed for any returned checks.
I understand and agree it is my responsibility to know if the physician or provider I am seeing is a contracted in-network provider recognized by my insurance company or plan. If the provider I am seeing is not recognized by my insurance company or plan, it may result in claims being denied or higher out of pocket expense to me. I understand this and agree to be financially responsible for all charges.
I understand and agree it is my responsibility to know if a referral is required to see a provider at Arvada Sport and Spine Group. If I have an HMO plan, I will obtain a referral if required by my insurance. I understand this and agree to be financially responsible and make full payment if I fail to do so.
By signing below, I also acknowledge that I have been informed of the cash services offered at this office and understand that these services are not billed to insurance, regardless of any statements made by my insurance provider regarding potential reimbursement. I agree to pay for these services in full at the time of service.

Patient / Agent / Guardian Signature Date _____

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Appointment Cancellation Policy

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Appointment Cancellation Policy

We appreciate your understanding of our scheduling policies, which are designed to ensure that all our patients receive timely and efficient care. Preparing for each appointment requires a significant investment of time and resources from our team. Late cancellations or no-shows disrupt our carefully planned schedule and affect our ability to provide quality care to other patients.

By providing sufficient notice for any changes to your appointment, you help us maintain a well-organized clinic environment and accommodate patients in need of care. Your cooperation with our policies is crucial to upholding the high standard of service we strive to provide.

To ensure fairness and continuity of care for all patients, Arvada Sport and Spine Group requires the following notice for cancellations or reschedules:

- General appointments: Notify us at least 24 business hours before your appointment to avoid a $50 fee per provider you are scheduled with.
- Massage Therapy: Notify us at least 24 business hours before your appointment to avoid a $50 fee.
- PRP and/or other Regenerative Procedures: Notify us at least 48 business hours before your procedure to avoid forfeiting your $200 deposit.

Late cancellations and no-shows make it difficult to fill appointment slots on short notice, impacting other patients' ability to receive timely care.

Please Note: Deadlines are based on business hours and exclude weekends and holidays. For example: If your general appointment is scheduled for 12:00 PM on Monday, notice must be provided by 12:00 PM on the preceding Friday.

Applicability of Fees: Due to the frequency of late cancellations and no-shows, fees may apply regardless of the reason.

Authorization of Charges: By scheduling an appointment, you acknowledge that failure to cancel or reschedule within the required timeframe will result in the corresponding fee being charged to the credit card on file. These charges are not covered by insurance and will be applied at the time of the missed appointment. If you would like a copy of this policy or any other consent form, you may request one from our office at any time.

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HIPPA CONSENT

Patient Information

Patient Name _____
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HIPPA Consent

HIPPA and Patient Privacy Consent

I acknowledge that I have certain rights regarding the privacy of my protected health information (PHI) as provided under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). By signing this consent, I authorized the practice to use and disclose my PHI for purposes permitted under HIPAA, including:

Treatment: This includes direct care provided by the practice and coordination with other healthcare providers involved in my treatment.
Payment: such as obtaining payment from third-party payers, including my insurance company.
Health Operations: Routine administrative, financial, and operations activities necessary for the practice to function effectively.

I acknowledge my right to review and am entitled to obtain a copy of the Privacy Statement upon my request, which provides a detailed explanation of how my PHI may be used and disclosed, as well as my rights under HIPAA.

I understand that the practice reserves the right to amend the terms of its Privacy Statement at any time. I may contact the practice to request the most up-to=date version of this notice.

I further understand that I may revoke this consent at any time by providing written notice to the practice. However, I acknowledge that any use or disclosure of my PHI made prior to the revocation date will remain valid and unaffected.

By signing below, I confirm that I have read, understood, and agree to the terms of this consent.

Patient / Agent / Guardian Signature Date _____

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PATIENT STATEMENTS & VERBAL ABUSE NOTICE

Patient Information

Patient Name _____
Date of Birth _____
Address _____
Phone Number _____

Patient Statements

Patient Statements Delivery - Effective March 1, 2025

Effective March 1, 2025, Arvada Sport and Spine Group will exclusively send patient statements electronically. We are committed to streamlining our communication processes.

Please take note of the following important information:

Electronic Statements: Starting March 1, 2025, all patient statements will be delivered electronically to the email address or phone number we have on file. It is crucial that you verify and update your email address with our front desk staff to ensure you receive statements promptly.

Opt-Out Option: If you prefer to receive paper statements instead of electronic ones, please notify our front desk staff. However, please be aware that opting out of electronic statements will incur a $3 administrative fee per paper statement to cover the cost associated with printing and postage.

We encourage you to review and update your contact information at your earliest convenience. Our team is available to assist you with any questions or concerns regarding this transition.

Thank you for your cooperation as we move towards more efficient and sustainable communication practices.

Patient / Agent / Guardian Signature Date _____

Verbal Abuse Notice

Attention Patients

We are committed to providing a safe and respectful environment for everyone.

Verbal abuse toward our staff is not acceptable and will not be tolerated. We appreciate your understanding and cooperation in maintaining a positive atmosphere for all.

Thank you for your understanding.

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PRIOR AUTHORIZATION POLICY

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Prior Authorization Policy

WHAT IS A PRIOR AUTHORIZATION?

A prior authorization is a process required by insurance companies to approve certain healthcare services before they are provided to ensure coverage. Prior authorization requests can be submitted verbally or through written documentation. While approval does not guarantee full coverage, it confirms that the proposed service meets the insurance company's requirements. Colorado law mandates that insurers respond to prior authorizations requests promptly, especially for urgent needs.

PROCUDERES
Some procedures recommended by your provider may require prior authorization to confirm insurance coverage. To assist with this:

- Arvada Sport and Spine Group will submit prior authorization requests for procedures as required by your insurance company.
- Even with a prior authorization approval, full payment is not guaranteed. You are still subject to coinsurance and/or deductibles as assigned by your insurance.

ARVADA SPORT AND SPINE GROUP'S PRIOR AUTHORIZATION POLICY
At Arvada Sport and Spine Group, we are committed to supporting you through the prior authorization process:

1. Treatment Authorizations: For treatments that require prior authorization, our team will handle the submission to your insurance company as necessary.
2. Support: While we cannot guarantee approval or coverage, our staff will provide necessary documentation and assistance to navigate the process efficiently.

If you have questions about this policy or need additional help, please reach out to a member of our staff. We are here to support your care needs.

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Patient Consent Form

Thank you for choosing Arvada Sport and Spine Group. After an examination, we may recommend chiropractic care, physical therapy, and/or other modalities as part of your treatment plan. The purpose of this consent form is to help you understand the potential benefits and medically significant risks associated with the treatments we offer, so you can make informed decisions whether to give or withhold your consent to any particular treatment. We are unable to anticipate and explain all risks and complications that may be associated with chiropractic care and physical therapy. The information below provides you with an overview of each type of treatment and informs you of potential benefits and medically significant risks known to us, but is not intended to be exhaustive. We encourage you to ask questions regarding any treatments that may be recommended to you.

Chiropractic:
The doctor of chiropractic evaluates the patient using standard examination and testing procedures. A chiropractic adjustment involves the application of quick force directed over a very short distance to a specific vertebra or bone. Adjustments are usually performed by hand but may also be performed by hand-guided instruments to improve mobility and function, and reduce muscle spasm. Chiropractic treatments generally are considered safe, but as with most types of health care, there are associated risks. The most commonly reported reactions include soreness and discomfort, headaches, tiredness, radiating discomfort, and dizziness, all of which usually disappear within 48 hours. Rare, but medically significant, risks associated with chiropractic care include, but are not limited to, fracture, joint dislocation, disc hernia or injury, increased symptoms of pain, or stroke. It is also possible that a patient will feel no improvement in symptoms of pain.

Physical Therapy:
The physical therapist evaluates the patient using standard examination and testing procedures. Physical therapy involves the manual application of specialized techniques to specific areas of the body to trigger a therapeutic response. Physical therapy almost always includes exercise, and can include stretching, core exercises, weight lifting, and walking. Your physical therapist also may use techniques such as heat, cold, water, ultrasound, and electrical stimulation. Beneficial effects associated with physical therapy include decreased pain, improved mobility, and increased flexibility and strength. Physical therapy generally is considered safe, but as with most types of health care, there are associated risks. The most commonly reported reactions include soreness, discomfort, and swelling as the body rehabilitates and recovers. Rare, but medically significant, risks associated with physical therapy include, but are not limited to, falls or accidents during physical therapy that can lead to further injury. It is also possible that a patient will feel no improvement in condition.

Trigger Point Dry Needling:
Trigger point dry needling (TDN) involves placing a small fusiform needle into the muscle at the trigger point in order to cause the muscle to contract and then release, improving the flexibility of the muscle and therefore decreasing the symptoms. TDN is a valuable treatment for musculoskeletal pain. Like any treatment there are possible complications. While these complications are rare in occurrence, they are real and must be considered prior to giving consent to treatment. Trigger point dry needling is not intended to stimulate any distal or auricular acupuncture points. Risks of the procedure: The most serious risk associated with TDN is accidental puncture of a lung (pneumothorax). If this were to occur, it may likely only require a chest x-ray and no further treatment. The symptoms of shortness of breath may last for several days to weeks. A more severe lung puncture can require hospitalization and re-inflation of the lung. This is a rare complication and in skilled hands should not be a concern. Other risks may include excessive bleeding (causing a bruise), infection and nerve injury. Bruising is a common occurrence and should not be a concern unless you are taking a blood thinner. As the needles are very small and do not have a cutting edge, the likelihood of significant tissue trauma from TDN is unlikely. Please consult with your practitioner if you have any questions regarding the treatment above.

I acknowledge that I have read and fully understand this patient consent form, I have had the opportunity to have questions answered by the doctor of chiropractic, and/or physical therapist as applicable. Based on this information and discussion with my provider(s), I consent to the following treatment(s) . I also understand that my consent is ongoing in the event that I choose not to accompany my child/minor to these events/sessions in the future. Consent may be revoked verbally or in writing at any time.

PLEASE INITIAL EACH TREATMENT TO WHICH YOU CONSENT:

_____ Chiropractic _____ Physical Therapy _____ Trigger Point Dry Needling

Print Patient Name: _____ Parent/Guardian: _____

Patient/Parent/Guardian Signature:_____ Date:_____