



Patient Financial Responsibility Statement

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

Patient Name _____
SSN _____

Date of Birth _____

INSURANCE & PATIENT RESPONSIBILITY

We will provide a **complimentary insurance verification check** as a courtesy. Patients are responsible for providing current insurance information and notifying us immediately of any changes. Insurance verification is not a guarantee of coverage or payment.

I understand and agree that I am financially responsible for all charges not paid by my insurance, including deductibles, copayments, coinsurance, out-of-network charges, non-covered services, and other benefit limitations. I understand that it is my responsibility to know my insurance benefits, including whether a referral is required and whether the provider I am seeing is in-network with my plan.

Insurance claims are submitted as a courtesy. I am responsible for following up with my insurance company regarding unpaid or denied claims and for payment of any balance that is my responsibility. We do not balance bill when prohibited by law.

CREDIT/DEBIT CARD ON FILE

A valid credit or debit card is required to be kept on file when scheduling an appointment. I authorize Arvada Sport and Spine Group to charge the card on file for applicable patient-responsible balances, missed appointment/late cancellation fees, deposits, and other charges authorized under our office policies.

If I have a deductible, copayment, coinsurance, or other patient responsibility, I authorize the practice to charge the card on file for amounts due in accordance with this Financial Policy. **After 30 days from the date of my first statement, any unpaid patient-responsible balance may be automatically charged to the card on file.**

If payment cannot be obtained and an account remains unpaid for 60 days after the first statement, the account may be referred to a collection agency. Collection fees of up to **30% of the amount owed**, as permitted by law, may be added. I understand that I may also be responsible for applicable collection costs, attorney fees, and court costs.

CASH SERVICES

Cash services offered by this office are **not billed to insurance** and are due in full at the time of service. Insurance reimbursement, if any, is the patient's responsibility to pursue.

PAYMENT METHODS

Arvada Sport and Spine Group accepts cash, checks, Visa, Mastercard, AMEX, and Discover. A **\$25 returned-check fee** will apply.

AUTHORIZATION & COMMUNICATION

I assign applicable insurance benefits to Arvada Sport and Spine Group and authorize the submission of insurance claims without obtaining my signature on each claim.

I authorize Arvada Sport and Spine Group and its employees, agents, and assignees to contact me by phone, email, text message, and automated telephone dialing systems regarding my care, appointments, billing, and account.

I understand that I have been informed of my privacy rights under HIPAA and authorize treatment after receiving an explanation of the proposed treatment, alternatives, and risks.

By signing below, I acknowledge that I have read, understand, and agree to this Financial Policy and accept financial responsibility for services provided to me.

Patient / Agent / Guardian Signature: _____ Date: _____



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Appointment Cancellation Policy

Patient Name _____

Date of Birth _____

We value our patients' time and our providers' time. Late cancellations and missed appointments prevent us from offering appointment times to other patients. Please provide the required notice when you need to cancel or reschedule.

REQUIRED NOTICE

- **Physical Therapy and Chiropractic:** At least **24 business hours** notice is required to avoid a **\$50 fee per provider scheduled**.
- **Massage Therapy:** At least **24 business hours** notice is required to avoid a **\$50 fee**.
- **Medical PRP and Other Regenerative Procedures:** At least **48 business hours** notice is required to avoid forfeiting the **\$200 deposit**.

Business hours exclude weekends and holidays. For example, for a Monday appointment at 12:00 PM, cancellation or rescheduling notice must be received by 12:00 PM the preceding Friday.

LATE CANCELLATIONS & NO-SHOWS

Late cancellations and no-shows **may be charged the applicable fee regardless of the reason**. Fees are not covered by insurance and are the patient's responsibility.

By scheduling an appointment, I acknowledge and agree to this cancellation policy. I authorize applicable cancellation, no-show, or forfeited-deposit charges to be processed using the **credit or debit card on file**.

A valid credit or debit card is required to be kept on file when scheduling appointments. If a card cannot be secured, the appointment may need to be cancelled or rescheduled.

I understand that I may request a copy of this policy or any other office consent form at any time.

Patient / Agent / Guardian Signature _____

Date _____



Additional Office Policies & Acknowledgments

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RESPECTFUL COMMUNICATION

Arvada Sport and Spine Group is committed to maintaining a safe, respectful environment for patients and staff. Verbal abuse, threats, harassment, or disrespectful behavior toward staff will not be tolerated.

PATIENT STATEMENTS

Effective March 1, 2025: Patient statements are sent electronically to the email address or phone number on file. Please keep your contact information current. Patients may request paper statements; a \$3 administrative fee per paper statement applies to cover printing and postage.

PRIOR AUTHORIZATION

Some services may require prior authorization from your insurance company before treatment. When required, Arvada Sport and Spine Group will submit the authorization request and provide necessary supporting documentation.

Prior authorization does not guarantee payment or coverage. You remain responsible for any applicable deductibles, copayments, coinsurance, or services not covered by your insurance. Insurance requirements and benefits are determined by your insurance company.

HIPAA / PATIENT PRIVACY CONSENT

I understand that my protected health information (PHI) may be used or disclosed as permitted by the Health Insurance Portability and Accountability Act (HIPAA), including for:

- **Treatment** – providing and coordinating healthcare.
- **Payment** – obtaining payment from insurance companies or other third-party payers.
- **Healthcare Operations** – administrative, financial, quality, and other activities necessary to operate the practice.

I understand that I have the right to review and request a copy of the practice's Notice of Privacy Practices and that the practice may amend its Notice as permitted by law. I may request the most current version at any time.

I understand that I may revoke this consent in writing; however, revocation does not affect disclosures already made in reliance on this consent.

By signing below, I acknowledge that I have read and understand these policies and consents.

Patient / Agent / Guardian Signature: _____ **Date:** _____

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 (TPDN) 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 (if under 18): _____

Patient/Parent/Guardian Signature: _____ Date: _____