Welcome to Our Office!

Date of Birth:

Patient Name:

Workers' Compensation Injury Claim: New Patient Package

Complete this package if:

- You were recently involved in a work injury (all ages).
- You have never been treated at our office.

Instructions:

1. Download and complete this package in its entirety.
2. Bring the following items with you on your first visit.
    a. Government issued photo-ID
    b. Insurance Card or Information
    c. Any medical records (including copy of advance imaging studies such as x-rays, MRI)
    d. Attorney Information (if you retained an attorney)
    e. Incident Report (if you have an incident report, from work)

Harmonious Living Chiropractic: Fitness & Wellness Center, LLC
10 South Street, Suite 403, Baltimore, Maryland 21202
Phone: 240-264-6372 | Fax: 1-888-375-5167
www.drtiffanybutler.com

Last updated on 01/01/2024

A. Patient Demographics

Name: _____ Last Name: _____Middle Initial: _____ DOB: _____

Social Security #: _____ Sex: □Female □Male Marital Status: □Single □Married □Divorced □Widow/er

Street Address: _____ City: _____ State: _____ ZIP: _____

Cell Phone: _____ Email: _____

Can we send you communications through text message and/or email such as appointments? □Yes □No

How did you hear about our office? _____

Emergency Contact Name: _____ Cell Phone: _____

Primary Medical Doctor: _____ Office Phone: _____

B. Complaint(s): What Brings You into The Office Today? (Mark the areas that hurt.)		
□Headache □Jaw Pain □Neck Back Pain □Mid/Upper Back Pain □Lower Back Pain □Pelvis Pain □Shoulder Pain □Upper Arm Pain □Elbow Pain □Forearm Pain □Wrist Pain □Hand Pain □Finger Pain □Thumb Pain □Hip Pain □Thigh Pain □Knee Pain □Leg Pain □Ankle Pain □Foot Pain □Toe Pain		
□Concussion □Dizziness □Nausea □Balance Issues □		
Do you have difficulty performing the following tasks due to your complaint(s)? (Circle all that apply)		
Sleeping	Walking	Standing
Lifting	Reaching	Carrying
Bending	Twisting	Driving
Riding in a Vehicle	Turning Over in Bed	Getting In/Out of Bed
Getting In/Out of a Vehicle	Performing House chores	Grooming/Bathing
Taking Care of Children/Dependents	Cooking	Working
Staying Asleep	Falling Asleep	Focusing
Concentrating	Reading	Using Computer
Use Work Tools	Toileting	Squatting
Using Stairs	Kneeling	Climbing
Exercising	Being Intimate	Other

C. Medication Usage (Please list any medications you are currently taking)	
Name of Medication	Use (Why are you taking it?)
D. Surgical Procedures (List any surgeries you have had)	
E. Hospitalizations	
Have you been hospitalized in the last 5 years? □Yes □No.	
F. Bodily Injuries	
Have you had any motor vehicle accidents? □Yes □No.	Have you had any dislocations? □Yes □No.
Have you had any falls? □Yes □No.	Have you had any fractures? □Yes □No.
G. ***FOR WOMEN*	
Are you currently pregnant? □Yes □No.	Have you given birth in the past? □Yes □No.
Have you had cesarean section? □Yes □No.	Have you had an epidural? □Yes □No.
H. Social and Lifestyle	
Do you take any minerals, herbs, vitamins or supplements? □Yes □No	Are you concerned about your weight? □Yes □No
Do you perform at least 30 minutes of physical activity or exercise daily? □Yes □No	How many hours of sleep do you normally get?
Do you drink alcohol? □Yes □No	Do you use tobacco? □Yes □No
Do you use recreational drugs? □Yes □No	How is your nutritional intake/diet? □Poor □Fair □Good
How would you rate your overall health? □Poor □Fair □Good	Do you want to become more physically fit? □Yes □No
Work: □Full time □Part time □Retired □Student □Unemployed	
I. Family History (If any blood relatives have the conditions, mark below)	
□Asthma □Emphysema □High Blood Pressure □Diabetes □Stomach Problems □Thyroid Disease □High Cholesterol □Heart Attack □Stroke □Seizures □Arthritis □Circulation Problems □Osteoporosis □kidney disease □Liver Disease □Mental Disorder □Cancer	

J. Medical History & Review of Bodily Systems: Check if you have (or had) any of the following health conditions or issues.

Pulmonary	Cardiovascular	Neurological
□Shortness of breath □Wheezing □Asthma □Bronchitis □COPD □Tuberculosis	□Heart surgery □Congestive heart failure □Murmur or valve issues □Heart stint □Pacemaker □Defibrillator □Angina/chest pain □Heart disease □Hypertension (High blood pressure) □Hypotension (low blood pressure)	□Visual changes □Loss of vision □Wear glasses □Double vision □Use a hearing aid □Loss of hearing □Loss of taste □Loss of smell □Memory loss □Difficulty hearing □Concussion □Head injury □Difficulty hearing □Epilespy/Seizures □Dizziness/Vertigo □Balance or coordination issues
Endocrine	**Renal/Nephrology**	**Gastroenterology**
□Thyroid disease □Hormone replacement therapy □Injectable steroid replacement □Diabetes	□Renal/Kidney stones □Hematuria (blood in urine) □Incontinence (difficulty urinate) □Bed-wetting □Bladder infections □Kidney disease □Kidney failure □Dialysis	□Nausea □Vomiting □Difficulty swallowing □Pancreatic disease □Irritable Bowel Syndrome (IBS) □Blood or black stools □Vomiting blood □Bowel incontinence (difficulty with bowel movement) □GERD/Acid Reflux
Hematology	**Dermatology**	**Lymphatic**
□Anemia □Auto Immune Disease □Abnormal bleeding disorder □Anemia □Hemophilia □Blood clots □Deep vein thrombosis □Anti-coagulant therapy	□Significant burns □Skin grafts □Psoriasis □Eczema	□Enlarged lymph nodes □Lymphedema
Musculoskeletal	**Reproductive**	**Psychology**
□Rheumatoid arthritis (RA) □Osteoarthritis □Gout □Brittle bones □Spinal fracture □Spinal surgery □Arthritis □Scoliosis □Metal implants/rods □Joint dislocation □Bone fracture	□Pregnancy □Childbirth □Miscarriage □Uterine fibroids □Erectile dysfunction □Enlarged prostate	□Psychiatric disorder □Depression □Anxiety □Schizophrenia □PTSD □Anxiety □Bipolar

Do you have any health conditions or concerns that the doctor and clinical staff should be aware of? □Yes □No

K. Acceptance as Patient

I understand and agree that the doctor(s) of **Harmonious Living Chiropractic: Fitness & Wellness Center, LLC** have the right to refuse to accept me as a patient at any time before treatment begins. The taking of history and the conducting of a physical examination are not considered treatment but are part of the process of information gathering so the doctor(s) can determine whether to accept me as a patient. I hereby authorize **Harmonious Living Chiropractic: Fitness & Wellness Center, LLC,** and its doctor(s) to administer care as they deem necessary to my care.

_____ _____ _____

Printed Name of Patient/Legal Guardian | Signature of Patient/Legal Guardian | Date

DO NOT WRITE IN THIS AREA – DO NOT WRITE BELOW THIS AREA – DO NOT WRITE BELOW THIS AREA – Clinical Use

Date Received: _____ Date Reviewed by Doctor: _____

Doctor Printed Name: _____ Doctor Signature: _____

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Date of Birth:

Patient Name:

Work Injury Information

Instructions: Complete this section to the best of your ability. Do not skip or leave spaces blank.

Date of Accident: _____ Time of Accident: _____ a.m./ p.m.

Where did the accident occur? □At work □Using a company vehicle □Other: _____

Was the accident reported to your supervisor or HR? □Yes □No Was an incident report given? □Yes □No

Were there witnesses? □Yes □No Did you take pictures of the accident? □Yes □No

If the work-injury is a result of a motor vehicle accident, complete below:

Road Conditions: □Dry □Damp □Wet □Snow □Ice □Other Road Visibility: □Good □Fair □Poor □Fog □Rain □Hail

Make and Model of Your Vehicle: _____ Make and Model of Other Vehicles: _____

How many vehicles were involved in the accident (including your vehicle)? □1 □2 □3 □4

Did you see the accident coming? □Yes □No Did you brace for impact? □Yes □No

Where were you inside of the vehicle? □Driver □Passenger Were their other passengers in the vehicle? □Yes □No

Did you wear lap and shoulder belt? □Yes □No Did the airbags deploy? □Yes □No Did the window(s) break? □Yes □No

Did you hit your head? □Yes □No Did you hit other body parts? □Yes □No Did you lose consciousness? □Yes □No

Did you experience the above body pain or symptoms before the accident? □Yes □No. If yes, what?

Did(do) you have any of the following (check all that apply): □Cuts □Bruising □Bleeding □Burns □Vomiting □Dizziness □Nausea

Post-Accident Details

Did you go to the hospital? □Yes □No If yes, how did you get there? □By ambulance □Drove myself □Someone drove me

Did you go to an outpatient facility (such as Urgent Care)? □Yes □No Did you see your primary medical physician? □Yes □No

If you received medical services after the accident, what services did you receive (check all that apply): □X-rays □CT scan □MRI

□Prescription for pain-killers □Prescription for muscle relaxants □Prescription for Inflammation □Pain Cream □Pain Patch □Injection

Explain in Your Own Words What Happened (in the space below):

_____ _____ _____

Printed Name of Patient/Legal Guardian Signature of Patient/Legal Guardian Date

Date of Birth:

Patient Name:

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Patient Insurance Information		
Primary Health Insurance Carrier Name:		
Member Number:	Group Number:	
Policy Holder Name:		Policy Holder Date of Birth:
Policy Holder Address:		
Would you like us to bill you for your health insurance on your behalf, in the event your auto insurance company does not cover your care?	□Yes □No □I'm not sure, please talk with my Attorney.	
Workers' Compensation Information		
Company Name:		
Policy Number:		
Claim Number:		
Adjustor Name:		
Adjustor Email:		
Adjuster Phone:		
Adjustor Fax:		
Phone Number:		
Fax Number:		
Employer Information		
Company Name:		
Phone:		
Attorney Information		
Do you have an attorney representing you?	□Yes □No *If "yes" provide their information below.*	
Attorney Name:	Law Firm:	
Office Address:	Email:	
Office Phone:	Fax:	

******Please provide a copy of your insurance card and/or declaration page to our office.******

Patient Financial Agreement

- The above information is true to the best of my knowledge. If I am using auto insurance (such as Personal Injury Protection) as a form of payment, I authorize insurance benefits to be paid directly to **Harmonious Living Chiropractic: Fitness & Wellness Center, LLC.**
- I hereby authorize **Harmonious Living Chiropractic: Fitness & Wellness Center, LLC** to release any medical information request to my insurance company to process the health claims for benefits.
- I hereby authorize payment of medical benefits to **Harmonious Living Chiropractor: Fitness & Wellness Center, LLC, and/or healthcare provider(s)** for services rendered to me.
- I understand that I am personally responsible for full payment of all charges and fees.
- I hereby authorize **Harmonious Living Chiropractic: Fitness & Wellness Center, LLC** to initiate a complaint to the Insurance Commissioner, or lawsuit against my insurance company for any reasons on my behalf, if I am using insurance as a form of payment.
- I understand that the amount my insurance company reimburses to **Harmonious Living Chiropractic: Fitness & Wellness Center, LLC, and/or healthcare provider(s)** may not satisfy the full payment in this case, I am financially responsible for paying the difference (e.g., the balance).
- I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing. I understand that nothing herein relieves me of my primary responsibility and obligation to pay for my medical services provided when a statement is rendered.

Printed Name of Patient/Legal Guardian _____ Signature of Patient/Legal Guardian _____ Date _____

Date of Birth:

Patient Name:

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Irrevocable Assignment of Benefits, Authorization and Lien

To Whom It May Concern:

I, _____, hereby authorize and direct my insurance company and/or attorney to pay directly to HARMONIOUS LIVING CHIROPRACTIC: FITNESS & WELLNESS CENTER, LLC (hereinafter referred to as "Office") such sums as may be due and owing this office for services rendered me, both by reason of accident or illness, and by reason of any other bills that are due to this office. I authorize to withhold such sums from any disability benefits, medical payment benefits, no fault benefits, health and accident benefits, workers' compensation benefits, or any other insurance benefits obligated to reimburse me from any settlement, judgement or verdict on my behalf as may be necessary to adequately pay the Office. I hereby further give a lien to the Office against any and all insurance benefits named herein, and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated for by the Office. This is to act as an assignment of my rights and benefits to the extent of the Office services provided.

In the event my insurance company obligated to make payments to me upon the charges made by the Office for their services refused to make such payments upon demand by me or the Office, I hereby assign and transfer to the Office any and all caused of action that I might have or that might exist in my favor against such company and authorize the Office to prosecute said cause of action either in my name or the Office name and further I authorize this Office to compromise, settle, or otherwise receive such claim or cause of action as they see fit.

I understand that I remain personally responsible for the total amount due to the Office for these services. I further understand agree that this *Assignment of Benefits, Authorization and Lien* does not constitute any consideration for the Office to await payments and the Office may demand payments from me immediately upon rendering services at their option.

I authorize the Office to release any information pertinent to my case to any insurance company, adjustor, or attorney to facilitate collection under this *Assignment of Benefits, Authorization and Lien.* I understand and agree that if this Office must take any action to collect an outstanding balance on my account, I will be responsible for payment of and will reimburse this Office for all costs of such collection efforts, including, but not limited to all court costs and all attorney fees.

_____	_____	_____
Printed Name of Patient/Legal Guardian	Signature of Patient/Legal Guardian	Date

Date of Birth:

Patient Name:

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Informed Consent to Chiropractic Care and Physical Therapy Rehabilitation Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic and rehabilitation procedures, including various mods of physiotherapeutic modalities, massage therapy, myofascial release trigger point therapy, diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic named below and/or other licensed Doctor of Chiropractic and Chiropractic Assistant(s) who now or in the future treat me while employed by, working at the practice or office listed below or any other practice or office. _____ **(Patient/Legal Guardian Initials)**

I had (or will have) the opportunity to discuss with the Doctor of Chiropractic named below and/or with the practice or office personnel the nature and purpose of chiropractic adjustments and other chiropractic and rehabilitation procedures. _____ **(Patient/Legal Guardian Initials)**

I understand and I am informed that, as in the practice of medicine, in the practice of chiropractic and physiotherapeutic modalities, there are some risks to treatment, including, but not limited to the following: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of adjustments of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and/or soreness following the first few days of treatment. The Doctor of Chiropractic will make every reasonable effort during the consultation, history taking, and physical examination to screen for contraindications to chiropractic care and rehabilitation procedures; however, if you have a condition that would otherwise not come to the Doctor of Chiropractic attention, it is your responsibility to inform the Doctor of Chiropractic. _____ **(Patient/Legal Guardian Initials)**

I do not expect the Doctor of Chiropractic to be able to anticipate and explain all risks and complications, and I wish to rely on the Doctor of Chiropractic to exercise sound judgement and expertise during the course of the procedures which the Doctor of Chiropractic feels at the time, based upon the facts they know, in my best interest. _____ **(Patient/Legal Guardian Initials)**

Other treatment options for my condition may include:

- Self-administered, over-the-counter analgesics, and rest;
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants, and painkillers;
- Hospitalization;
- And surgery

If I choose to use one of the above "other treatment" options, I should be aware that there are risks and benefits of such options and I may wish to discuss these with my primary medical physician. _____ **(Patient/Legal Guardian Initials)**

I acknowledge that I will (or have) discussed the following with the Doctor of Chiropractic: 1) the condition(s) that the treatment is to address; 2) the nature of the treatment; 3) the risks and benefits of that treatment; and 4) any alternatives to that treatment prior to receiving treatment at this office. _____ **(Patient/Legal Guardian Initials)**

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS.

I have read or have read to me the above statement. I have also had (or will have) the opportunity to ask questions about its content and receive answers regarding the treatment. By signing below, I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment at Harmonious Living Chiropractic: Fitness & Wellness Center, LLC.

_____	_____	_____
Printed Name of Patient/Legal Guardian	Signature of Patient/Legal Guardian	Date
_____	_____	_____
Printed Name of Doctor of Chiropractic	Signature of Doctor of Chiropractic	Date

Date of Birth:

Patient Name:

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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. This practice is required, by law, to maintain the privacy and confidentiality of your protected health information (PHI) and to provide our patients with notice of our legal duties and privacy practices with respect to your PHI.

Disclosure of Your Healthcare Information

- **Treatment:** We may disclose your healthcare information to other healthcare professionals within our practice for the purpose of treatment, payment, or healthcare operations. For example, on occasion, it may be necessary to seek consultation regarding your condition from other healthcare providers associated with this practice. It is our policy to provide substitute healthcare provider(s), authorized by this practice, to provide assessment and/or treatment to our patients, without advanced notice, if your primary healthcare provider's absence due to vacation, sickness, or another emergency situation.
- **Payment:** We may disclose your healthcare information to your insurance provider for the purpose of payment of healthcare procedures and/or operations. For example, as a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to this practice for healthcare services rendered. If you pay your healthcare services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the healthcare services rendered.
- **Workers' Compensation:** We may disclose your healthcare information as necessary to comply with State Worker's Compensation laws.
- **Emergencies:** We may disclose your healthcare information to notify or assist in notifying your family member, or another person responsible for your care, about your medical condition or in the event of an emergency or of your death.
- **Public Health:** As required by law, we may disclose healthcare information to public health authorizes for purposes related to preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings

We may disclose your healthcare information during any administrative or judicial proceedings.

Law Enforcement

We may disclose your healthcare information to law enforcement officials for purposes such as identifying or locating a suspect, fugitive, material witness, or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons

We may disclose your healthcare information to coroners or medical examiners.

Organ Donation

We may disclose your healthcare information to organizations in procuring, banking, or transplanting organs and tissues.

Research

We may disclose your healthcare information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety

In may be necessary to disclose your healthcare information to appropriate persons to prevent or lessen a serious and imminent threat to the health and safety of a person or to the public.

Specialized Government Agencies

We may disclose your healthcare information for military, national security, prisoner, and government benefits purposes.

Marketing

We may contact you for marketing purposes or fund-raising purposes, as described here. For example, as a courtesy to our patients, it is our policy to call your home and/or cell phone on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not available, we will leave a reminder message on your answering machine and/or voice mail, or with the person answering the phone. No personal healthcare information will be disclosed during this recording or message other

than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment. It is our practice to participate in charitable events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home and/or cell phone to invite you to participate in the chartable activity. We will provide you with information about the type of activity, the dates, and times, and request your participation in such an event. It is not our policy to disclose any personal healthcare information about your condition for the purpose of practice sponsored fund-raising events.

Change of Ownership

If this practice is sold or merged with another organization, your healthcare information and medical record will become the property of the new owner.

Your Healthcare Information Rights

1)You have the right to request restrictions on certain uses and disclosures of your healthcare information. Please be advised, however, that this practice is not required to agree to the restriction that you requested. 2) You have the right to have your healthcare information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request. 3) You have the right to inspect and copy your healthcare information. 4) You have the right to request that this practice amend your protected healthcare information. Please be advised, however, that this practice is not required to agree to amend your protected healthcare information. If you request to amend your healthcare information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree and/or appeal the denial. 5) You have the right to receive an accounting of disclosures of your protected healthcare information made by this practice. 6) You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

This practice reserves the right to amend this Notice of Privacy Practices at any time in the future and will make new provisions effective for all information that it maintains. Until such an amendment is made, this practice is required by law to comply with this Notice of Privacy Practices. This practice is required by law to maintain the privacy of your healthcare information and to provide you with notice of its legal duties and privacy practices with respect to your healthcare information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact us by calling this office.

Complaints

Complaints about your privacy rights, or how this practice has handled your healthcare information should be directed to our office by calling this office. If you are not satisfied with the way this office handles your complaint, you may submit a formal complaint to the Department of Human Health Services.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE NOTICE OF PRIVACY PRACTICES

I have read or have read to me the Notice of Privacy Practices. I have also had the opportunity to ask questions about its content and receive answers regarding the notice. I understand my rights contained in the notice. By way of my signature, I provide this practice with my authorization and consent to use and disclose my protected healthcare information for the purposes of treatment, payment, and healthcare procedures and/or operations as described in this Notice of Privacy Practices.

_____	_____	_____
Printed Name of Patient/Legal Guardian	Signature of Patient/Legal Guardian	Date

Date of Birth:

Patient Name:

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Acknowledgement of Our Patient Care and Management Statement

At Harmonious Living Chiropractic: Fitness & Wellness Center, we want to make patients aware of policies that relate to patient care and management. Take a few minutes to become familiar with our policies as they pertain to patient care and management. To view an additional policy's view *HLC Patient Handbook* available online at www.drtiffanybutler.com

Scheduling Appointment(s): All patients must schedule an appointment to be seen by our doctor(s). You can schedule by calling the office at (240) 264 – 6372 during our normal business hours, Monday – Friday 10:00 a.m. – 7:00 p.m.; Saturday – Sunday 8:30 a.m. – 12:00 p.m. EST: and online by visiting www.drtiffanybutler.com. **Hours of operation and/or clinical hours are subject to change based on the doctor's availability.*

Appointment(s) Reminder: We do our best to provide patients with reminders of their scheduled appointment(s) using one or more of the following methods: phone call, text message and/or email. Patients must opt-in to receive appointment reminders.

Late Arrival to Appointment(s): Patients will receive a 10-minute grace window. If you are more than 10 minutes late for your scheduled appointment, we will do our best to have you seen by the doctor. However, you may have to wait if other scheduled patients arrive on time for their appointment. If you are more than 10 minutes late for your appointment, you may be asked to reschedule for another day/time.

Cancel or Reschedule Appointment(s): If you need to cancel or reschedule your appointment(s), please provide 24-Hour notice in advance by calling (240) 264 – 6372, if no one answer, leave a voice mail message including only your name, phone and that you are either "cancelling" or "would like to reschedule" an appointment. If you fail to cancel or reschedule your appointment within 240Hours of your scheduled appointment, you may be charged a **$25 No-Show Fee**. This fee cannot be billed or reimbursed by the insurance company and is therefore, the patient's responsibility to pay this fee, if/when charged.

Missed Appointment(s): If you miss a scheduled appointment, it is considered a "No-Show." A missed appointment will be documented in the patient's medical file as such. If a patient misses 3 or more consecutive scheduled appointments, they may be dismissed from the office at the discretion of the doctor.

Cell Phone Use: To ensure that we create a positive environment, we ask that you do not use your cell phone while in the office or when interacting with staff. This includes talking, texting, watching videos, listening to music, taking pictures and/or videos without prior permission. We ask that you demonstrate respect and consideration towards others who are sharing space with you. We have the right to ask you to stop using your cell phone if you are in violation of this policy. If you need to make a phone call, we ask that you do so outside of the office.

Zero Tolerance: We have a zero-tolerance policy for bullying, threatening, and/or discriminating of any kind towards patients, employees, independent contractors and/or staff. We ask when you are communicating to employees, independent contractors, staff, and/or other patients, that you speak with courtesy and respect to ensure that we provide the best service possible and to resolve any issues or concerns you have.

Patient Financial Responsibility: The patient is responsible for payment of all services received by the office, including co-payments, co-insurance, outstanding balances, and/or other fees, when applicable. Payment for services is due on the day services are received and is payable to the office. The patient is response for services not covered by insurance, even if it is considered a covered service but was denied by insurance. It is the patient's responsibility to determine if their insurance plan covers services that are provided to them and/or if they require a referral or pre-authorization prior to receiving treatment at our office.

Patient Dismissal: A patient may be dismissed from our office for one or more of the following reasons: excessive missed schedule appointments, non-compliance with recommended treatment plan(s) by the doctor, hostile and/or threatening behavior towards another patient or staff; and demonstrating inappropriate, abuse and/or violent behavior.

Treatment Policy: Only patients are allowed in the treatment area(s). The doctor(s) treat patients by appointment only. Drop-ins and/or walk-ins are not permitted and cannot be accommodated.

Referral to Specialists: Referrals are provided to the patient based on the discretion of the doctor(s). If you need a referral, you must schedule an appointment with the doctor first, to determine the appropriate referral.

Food & Drink: Patients are allowed to drink water in the waiting/reception area. No food or drink is permitted in treatment areas and exam rooms, to avoid potential contamination of surfaces.

Printed Name of Patient/Legal Guardian	Signature of Patient/Legal Guardian	Date

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Date of Birth:

Patient Name:

Authorization to Release Medical Information/Records

This Authorization is HIPAA complaint for use or disclosure of Protected Health Information.

By signing below, I, _____, authorize to use and disclose the protected health information (PHI) identified below concerning:

Patient Name: _____ Date of Birth: _____ SSN: _____

This authorization includes the release of the following information to:

Dr. Tiffany T. Butler
Harmonious Living Chiropractic: Fitness & Wellness Center, LLC
10 South Street, Suite 403, Baltimore, Maryland 21202
Phone: 240.264.6372 | Fax: 1.888.375.5167

I understand that I have the right to inspect and receive a copy of the information to be disclosed. I understand that I may revoke this authorization at any time in writing, except to the extent that action has been taken based on this authorization. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to consent to a claim under my policy.

Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.

I have read the above foregoing *Authorization for Release of Information* and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____	_____	_____
Printed Name of Patient/Legal Guardian	Signature of Patient/Legal Guardian	Date