Dr. Brian Harasha

Terms of Acceptance for Care

When a patient seeks my services for health care and I accept a patient for such care, it is essential for both to be working towards the same objective. Dr. Harasha provides his services to improve upon health. Health is a state of optimum physical, mental and social well-being, not merely the absence of diseases or infirmity.

Chiropractic Adjustment and Vertebral Subluxation: An adjustment is the specific application of forces to facilitate the body's correction of Vertebral Subluxations. Subluxations are also known as spinal nerve interference. A misalignment or inappropriate tension on one or more of the 24 vertebrae in the spinal column causes alteration of nerve function, resulting in a lessening of the body's innate ability to express its maximum health potential. My chiropractic method of correcting subluxations is by specific adjustments on or around the spine using gentle forces or an instrument.

Acupuncture and Qi: Acupuncture is the ancient Chinese art and science of inserting extremely fine needles into the body to open and unblock energy or 'Qi'. Acupuncturists may also use low voltage electrical instruments to stimulate acupuncture points. Acupuncture points are located on the body and are stimulated in such a way as to increase, decrease, or even re-direct the flow of energy in the body. This is a very simple explanation for the complex process that takes place in the body during acupuncture.

Laser therapy: The use of light (photons) to provide higher amounts of energy to our cells which in turn facilitates cellular functions and healing like resolving inflammation, reducing pain and remodeling of tissue. The light is high power but provided in a form that is warm and comfortable, not hot.

Nutritional Supplements and herbs: Any mention of nutritional supplements and herbs are only recommendations presented by the chiropractor. They are not part of any diagnosis or treatment of a condition, but are recommended solely to help the general balance of the body and increase health.

Yoga or exercise: Any mention of yoga or exercises are only recommendations presented by the chiropractor. They are not part of any diagnosis or treatment of a condition. When not in direct company of the chiropractor they are done at your own risk with no liability on the chiropractor's part if injury is sustained.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation or altered energy flow. However, if during the course of a spinal examination, we encounter unusual findings that are not related to vertebral subluxation or altered energy flow, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by other. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only methods are specific adjusting to correct vertebral subluxations and/or acupuncture.

I, _____ have read and fully understand the above statements.

(print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

_____ _____

(signature) (date)

Dr. Brian Harasha

Consent for Purposes of Treatment, Payment & Healthcare Operations

In this document, “I” and “my” refer to the patient,
and “Chiropractor” refers to Brian Harasha, D.C. of Creative Wellness, LLC.

I consent to the use or disclosure of my protected health information by Chiropractor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Chiropractor. I understand that analysis, diagnosis or treatment of me by Chiropractor may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Chiropractor is not required to agree to the restrictions that I may request. However, if Chiropractor agrees to a restriction that I request, the restriction is binding on Chiropractor. I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractor has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Chiropractor and understand that I have a right to fully understand that Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Chiropractor. The Notice of Privacy Practices for Chiropractor is also posted in the examination room at 2558 S. Brentwood Blvd., St. Louis, MO 63144. This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information.

Chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Chiropractor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative Printed Name of Patient

_____ _____

Date of Signing Description of Personal Representative’s Authority

Cancellation/No-Show Policy

Dr. Harasha runs a full schedule and if a patient does not show up it takes away the opportunity for someone else who is trying to get in. It is also a financial loss that cannot be recovered. Dr. Harasha's Cancellation/No-Show Policy is both strict and lenient. It is strict because there are no exceptions and the reason for not showing does not matter. We do not want to be the ones to determine if a reason is valid or not. It is lenient because there is room for error before financial consequences. Cancellation with less than 24 hours' notice is considered a No-Show. Notice that in the 24hr rule – voice messages after hours the day before are too late. The policy is as follow:

- The first No-Show is Free. Dr. Harasha knows things come up.
- The Second No-Show is charged at 50% of that visit's rate. This will be charged to the credit card on file. If it is declined, a statement will be sent to the patient and can be paid at the next visit or before.
- The Third No-Show is charged at 100% of that visit's rate. This will be charged to the credit card on file. If it is declined, a statement will be sent to the patient and Dr. Harasha will not schedule the patient again until it is paid in advance.

By signing this form, the patient agrees to pay any fees related to this No-Show policy. This policy remains in effect indefinitely or until an official change is made. This policy was also explained in person by Dr. Harasha or his staff.

** there is absolutely no leniency for Lien based cases and the fee paid is Not reimbursable to the patient **

☐ I agree to store my valid credit card on file and to agree to allow Creative Wellness, LLC to charge my card as described in this agreement. Dr. Harasha or his staff discussed this with me in person: _____ (staff initials).

Signed: _____ _____ _____

Patient Name (Print) Patient Signature Date

Financial Policy

Creative Wellness, LLC is a fee-for-service business that also accepts delayed third-party payments (insurance). We do our best to estimate the total due at each visit by calling your insurance company and asking the specifics of your policy. You will be asked to pay the estimated patient's responsibility at each visit. This payment can be made by cash, check, credit card, or credit card on file. There may be occasions where the estimate is off and a credit or a billing statement will be made to balance out any discrepancies. You are expected to pay the full cost of the services received based on our fee schedule (cash pay) and/or contracted rates of your insurance plan. You also are agreeing to allow us to send medical information and billing information to your insurance company as required by them.

☐ I agree to pay the full cost of the services received based on the fee schedule (cash pay) and/or contracted rates of my insurance. I am responsible for all fees if my insurance company or lien does not pay.

Signed: _____ _____ _____

Patient Name (Print) Patient Signature Date