Full Motion LIFE & SPORT

6013-B Wilson Blvd
Arlington, VA 22205
Phone: 703-536-5900
Fax: 703-536-5902
Dr. Olya Morgen, D.C.
Dr. Jake Oergel, D.C.

Office Policy and Assignment of Payments

Appointments:

- Please show up for your appointments ON TIME. We maintain an exceptional record for running on time and expect the same from you. If you are late, you are causing the doctor to run late and then the next patient has to wait. Please show respect for other patients.

Missed Appointments:

- If you need to cancel your appointment, please give us at least 24 hours notice.
- After the first "No Show" you will be given a phone call and a reminder that the office visit was missed.
- After the second and subsequent missed appointments a "Missed appointment" charge of $25.00 will be sent to the patient. This charge is not billable to the insurance company.
- In the event of inclement weather and you do not feel it is safe to drive here, please call us.

Payment Policy:

- Any required payments are expected at the time of each visit.
- If the insurance company does not pay in full, according to the terms of the patient's policy, the patient will be responsible for all unpaid charges.
- It is the patient's responsibility to keep track of the dollar amount limits, number of authorized visits (if necessary), changes for co-payments, deductibles, etc. for their insurance policy.
- Full Motion Life & Sport P.C. will call to verify your insurance benefits at the time of your initial visit, however, as stated by your insurance company "these are an estimate of benefits and not a guarantee of payment".
- I acknowledge that I am ultimately responsible for payment of my bill and any service charges that are incurred in collecting payment for my bill including attorney fees, interest, and court costs if applicable.

HMO/POS/PPO Referrals/Authorization:

- If an insurance company requires a referral for the initial visit, this referral needs to be received by our office before the patient is seen. Obtaining this initial referral is the patient's sole responsibility and all charges incurred due to improper referral procurement will also be the patient's responsibility.
- If an insurance company requires an additional referral or authorization for further treatment, Full Motion Life & Sport P.C. will provide the patient with the necessary documentation, or we will fax it directly to the primary care doctor's office. However, it is ultimately the patient's responsibility to obtain the referral or authorization.

Copies of Records:

- Full Motion Life & Sport P.C. reserves the right to charge an administrative fee of 25 cents per page for the copying and/or sending of clinical records. We also reserve the right to charge 25 dollars for the initial page and 10 dollars per page thereafter for any written reports, requests or forms pertaining to the patient's condition.

As a courtesy to our patients, we will submit medical claims to your primary and secondary insurance. In signing this form, you agree that we may bill your insurance company on your behalf and you agree to ASSIGN PAYMENTS to Full Motion Life & Sport P.C. This means that you will give permission for the insurance payments to be made directly to us. If you do not agree to this, we require payment directly from you at the time of service and we will then provide you with the necessary documentation to file your own insurance papers.

I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement of any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submission.

I hereby convey to the above named doctor(s) and clinic to the full extent permissible under the law and under any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor(s) and claim and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with the doctor and clinic in any attempts by such doctor(s) and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including—if necessary—bring suit with such doctor(s) and clinic against such insurers and/or employee health care plan in my name but at such doctor(s) and clinic's expense.

I have read the above agreement. I understand and agree to all of the points discussed above.

Name (Printed):_____

Name (Signed):_____Date:_____

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Patient Consent for Use and/or Disclosure of Protected Health Information To Carry Out Treatment, Payment and Healthcare Operations

I,_____, hereby state that by signing this Consent, I acknowledge and agree as follows:

1. A copy of Full Motion Life & Sport's (hereafter referred to as the "Practice") Privacy Notice is available at any time. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders or communications that will be used by the Practice:
    a. A postcard mailed to me at the address provided by me; and
    b. Telephoning my home and leaving a message on my answering machine or with the individual answering the phone.
4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.
5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to my restrictions that I have requested. If the Practice agrees to a requested transaction, then the restriction is binding on the Practice.
6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this Consent.
7. I understand that if I revoke this Consent at any time, the Practice has the right to refuse to treat me.
8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the preceding notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____
Name of Individual (Printed) Signature of Individual

_____ _____
Signature of Legal Representative* Relationship to Individual

Date Signed: _____/_____/_____

* Attorney-In-Fact, Guardian, Parent if a minor

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Informed Consent to Physical Medicine, Joint Manipulation and Manual Therapy

Please read this entire document prior to signing. It is important that you understand the information it contains. Please feel free to ask questions if anything is unclear.

- **As part of your analysis, examination and treatment, you are consenting to any and all of the following procedures:**

Spinal Manipulative Therapy	Extremity Joint Manipulation	Range of Motion/Neurological Testing
Muscle Strength Testing	Orthopedic Testing	Motion Palpation
Muscular Palpation	Vital Signs	Active Release Techniques (ART)
Electrical Stimulation Therapy	Ultrasound Therapy	Gait Analysis
Hot/Cold Therapy	Postural Analysis	Therapeutic Exercises
Myofascial Release Therapy	Trigger Point Therapy	Kinesio Taping Therapy

- **The material risk inherent in Active Release Techniques/Myofascial Release Therapy**
  Active Release Techniques (ART) is a hands-on soft tissue treatment method. You will physically move the region of the body getting worked on through active ranges of motion. ART may be uncomfortable in some regions of the body (like the burn experienced while lifting weights) and may produce soreness post-treatment for up to 1-3 days.

- **The nature of spinal/extremity joint manipulation**
  After a full evaluation of your condition, the doctor may make the decision that manipulative therapy would be beneficial to assist your recovery. If joint manipulation is used, the doctor would use their hands in such a way as to move your joints to restore range of motion, proper function and reduce the perception of pain. You may feel a click or pop, similar to someone cracking their knuckles, and you may feel movement of the joint.

- **The material risk inherent in joint manipulative therapy and ancillary procedures**
  As with any health procedure, there are certain complications which may arise following joint manipulation therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscular strain or cervical myelopathy. Some types of manipulation of the neck have been associated with injuries to the arteries of the neck leading to or contributing to serious complications including stroke. Some patients will feel some soreness and stiffness during the first twenty four to forty eight hours following their first and/or second treatment utilizing joint manipulation. Your doctor will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to the doctor's attention, it is your responsibility to inform them.

- **The probability of those risks occurring**
  Fractures are rare occurrences and generally result from some underlying weakness of the bone which is checked for during the taking of your history and during examination. Stroke has been a subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical manipulations. The other complications are also described as rare.

- **The availability and nature of other treatment options**
  Other treatment options for your condition may include: Self administered over-the-counter analgesics and rest; Medical care and prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; Hospitalization or Surgery. If you chose to use one of the other treatment options, you should be aware that there are risks and benefits associated with such options and you may wish to discuss those with your primary care physician or specialist.

- **Procedures you would like excluded from your treatment**
  If there are any procedures previously listed that you would explicitly request not to be employed in your treatment, please list them below. We will gladly employ other treatment options in an attempt to reach the same results.

  _____

- **The risks and dangers of remaining untreated**
  Remaining untreated may allow the formation of adhesions and reduced mobility which may set up a pain reaction, further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

I have read all of the information listed here and have had the opportunity to pose any questions regarding any information I may have found unclear. I fully understand and consent to have these treatments—excluding any exceptions listed above—performed on me during my initial examination and any follow-up visits.

Name (Printed):_____

Name (Signed):_____ Date:_____