TERM OF ACCEPTANCE

Patient Name: _____ Date: _____

The goal of Apex Health Spine & Sport is to enable patients to gain control of their health. To attain this, we believe communication is the key. There are often topics that are hard to understand, and we hope this document will clarify those issues for you. Please read the paragraphs below. If you have any questions, please feel free to ask one of our staff members.

INFORMED CONSENT

A patient, in coming to Apex Health Spine & Sport, gives the health care provider permission and authority to care for the patient in accordance with the performed tests, diagnosis, and analysis. The treatments and clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. The provider, of course, will not give any treatment or care if he/she is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make known to the provider any previously diagnosed pathological defects, illnesses or deformities which would otherwise not come to the attention of the provider. The healthcare professional provides a specialized, non-duplicating healthcare service. The provider is available to work with other types of providers in your healthcare regimen.

I understand that if I am accepted as a patient by a provider at Apex Health Spine & Sport, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any potential risk involved will be explained to me upon my request.

I give consent to request my RX (medical prescription) history online.

I give consent to keep my encrypted credit card information on file for any future authorized payments.

MISSED APPOINTMENTS

While we are sensitive to the fact that any emergency may occur in a rare instance, last minute patient cancellations or patient no-shows decrease our ability to accommodate the scheduling needs of other patients. Therefore, a scheduled appointment **MUST BE CANCELLED AT LEAST 24 HOURS IN ADVANCE,** or a **$20.00 FEE** will be charged for that appointment. Failure to show up for an appointment **(NO SHOW)** will result in a **$20.00 FEE**. The patient is responsible for these fees, not the insurance company or third-party payer. Repeated failure to comply with this policy may result in your name being placed on a "Schedule Based on Availability" list. This will require you to call for an appointment on the day you wish to have an appointment to see if there is an opening. We believe that this policy is necessary for the benefit of all our patients, so that we may continue to provide the highest quality treatment and service to everyone.

WOMEN ONLY

To the best of my knowledge, **I AM NOT** pregnant, and **I GIVE PERMISSION to x-ray** for diagnostic interpretation. **I agree to inform Apex Health Spine & Sport if this changes at any point in the future.**

CONSENT TO EVALUATE AND TREAT A MINOR

I verify that I am the parent or legal guardian. I have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive care.

ACKNOWLEDGEMENT

I have read and fully understand the above statements. I have had the opportunity to review the notice of privacy practices (HIPAA) and have been provided opportunity to discuss my right to privacy. Upon request I will be given a copy.

Patient Signature: _____ Date: _____