Community cTx TherapeutiX

ctxcares.com

Office: 860-848-4180 | Fax: 860-574-9393 • 601B Broad Street | New London, CT 06320

Patient Name:_____ DOB:_____

Address:_____
Street City/State Zip Code

Mailing Address:_____
Street City/State Zip Code

Home Phone:_____ Cell:_____ Work:_____

Sex: M / F / NB Marital Status: S M D W Email: _____

Employer:_____
Name Address Phone

Person to Notify In Case of Emergency_____
Name Relationship

_____
Phone Address

Person Responsible for Bill if Patient is a Minor:

Guarantor Name:_____ DOB:_____

Address:_____

Phone:_____ SSN:_____ Relationship to patient:_____

Employer:_____
Name Address Phone

Health Insurance Information — Please provide the office with a current copy of insurance card(s)

Primary Ins:_____ ID#_____ Group #_____

Policy Holder:_____
Name Address Phone

_____
DOB SSN Employer Relationship to Patient

Secondary Ins:_____ ID#_____ Group #_____

Policy Holder:_____
Name Address Phone

_____
DOB SSN Employer Relationship to Patient

Tertiary Ins:_____ ID#_____ Group #_____

Policy Holder:_____
Name Address Phone

_____
DOB SSN Employer Relationship to Patient

_____ _____

Signature (of person completing form) Date

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Patient Consent and Authorization
Acknowledgement of Receipt of Notice of Privacy Practices
Acknowledgement of Receipt of Cancellation/No-Show Policy

*I hereby authorize Community Therapeutix (CTX) personnel and contracted staff to perform any and all tests or procedures relative to my care, injury/illness and/or physical examination as deemed necessary and advisable by the provider and/or employer.
*I hereby give permission to my third-party payer (Insurance carrier, PPO, HMO, employer) to directly pay CTX for services rendered to me. I understand I am responsible for any applicable balance remaining after my insurance has paid and I am to pay the difference within 30 days of notification by CTX or my insurance company.
*I have been made aware that if the physician does not participate with my health insurance plan, I will be responsible for any applicable charges.
*I understand and accept that I must pay for any charges which I am billed by CTX. I understand that if these medical bills are not paid on time, they may be turned over to a collection agency. If this happens, I understand that I will have to pay, and I agree to pay reasonable collection and attorney fees in addition to lawful interest and cost.
*This office participates with an electronic medical record.
*This authorization will remain in effect until revoked in by me in writing except to the extent that the practice already made disclosures in reliance upon my prior consent.
*I hereby acknowledge I have received a copy of the Notice of Privacy Practices. I understand if I have any further questions or complaints I may contact: CTX at 860-848-4180.
*I also understand that I am entitled to receive updates, upon request, if the Notice of Privacy Practices is amended or changed in a material way.
*I hereby acknowledge I have received a copy of the Cancellation/No-Show Policy and understand my responsibilities regarding this policy.
*My signature below indicates that I have read and understand each of the paragraphs above.

_____ _____
Date Signature of Patient or Legally Authorized Representative*

*If Legally Authorized Representative: Relationship to Patient: _____

_____ _____
Date Staff Signature

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Patient Permission Form

Patient Name:_____Date of Birth: _____

I authorize Community Therapeutix and employees to release medical information, such as, test results, appointments, and information about medication I have been prescribed to:

*Please circle who we may leave this information with:

Spouse

Children

Parent(s)

Other Family Members (please specify):

_____

Other (Please specify):

_____

I do not want messages left with anyone other than myself.

_____
Signature

I give permission for information to be left on my answering machine. Please check **all** that apply:

_____ Appointments at Hospital
_____ Appointments with other Physicians
_____ Test Results
_____ Information regarding prescriptions that I am taking or changes in prescriptions
_____ Reminders about upcoming appointments in this office.

Signature:_____Date:_____

If you would like a copy of this policy to keep, please ask the front desk

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Cancellation/No-Show Policy

We value our patient/provider relations and will do everything we can to accommodate each patient. Communication and compliancy are not only very much appreciated but will enable us to help the patients to achieve positive outcomes.

Patients who are unable to keep their appointment are required to provide 12-hour notice of cancellation. To ensure availability of appointments to our patients, we have adopted a "no-show appointment" policy. Patients who miss two appointments are subject to a record review by your health care provider. Your health care provider will determine if you can continue to receive care in our practice.

Policy:

- Patients must provide **12-hour notice** for appointment cancellation
- Patients who fail to cancel their appointment without proper notice will have their appointment flagged as a no-show.
- **Patients with a no-show may be charged a fee of $40 per missed appointment.**
- **Patients with two no-shows may be discharged from the practice**. However, documented extenuating circumstances will be taken into consideration.
- The Practice will assist our patients in keeping appointments by utilizing various reminder systems which include staff reminder calls to patients, appointment cards, etc. It is the patient's responsibility to keep contact information updated to ensure delivery of the reminders.
- In the event the health care provider decides to discharge the patient, the practice will send a letter of discharge via certified mail to the patient. Documentation will be made in the demographic screen in the computer system and the office manager will be made aware of the discharge. The practice will continue to provide care up to 30 days to permit the patient to make alternative healthcare arrangements. A copy of the discharge letter will be scanned/filed in the patient's record.

I have read and understand the Cancellation/No-Show Policy at Community Therapeutix. I acknowledge that I will be responsible for a $40 No-Show fee if I no-show or fail to cancel within the allowed time for my scheduled appointment.

_____	_____	_____
Print Name	Signature	Date

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Waiting Room Safety Policy

At Community Therapeutix, the safety of our guests is one of our top priorities and we will do everything possible to ensure our office is a safe environment for everyone to visit.

Please note that the waiting area is NOT supervised by staff and therefore, we cannot guarantee the safety of minors not under the supervision of their accompanying adults. We welcome the use of the waiting room for younger guests of clients while visiting, we just ask and appreciate your compliance.

As of January 1, 2020, we will be implementing the following policy:

- Children under the age of 12 cannot be left in the waiting area without an adult 18 years or older.
- If you are a parent/guardian of a client, and would like to participate in the scheduled session, please arrange for another adult to supervise any other minors that may need to wait during the duration of the appointment.
- Staff is not responsible for the supervision of minors under the age of 18. If you have a minor 12 years of age or older, it is up to your discretion of their ability to self-supervise while in the waiting area. Minors between the ages of 12 and 17 will not be permitted to supervise other minors.

I have read and understand the Waiting Room Safety Policy and acknowledge that Community Therapeutix and their staff are not responsible for the supervision of any minor accompanying me. If I am unable to provide supervision for any minor, I understand that I will need to reschedule my appointment 24 hours in advance to avoid the application of the No-Show charge.

_____	_____	_____
PRINT CLIENT NAME	CLIENT/GAURDIAN SIGNATURE	DATE

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Todd Stelik, OTR/L, CHHP, Assistant Director

Statement of Practice

I, Todd Stelik, am not a medical doctor, licensed physician, naturopathic doctor or registered dietician, nor do I portray myself as such. I do not assess the nutritional needs of individuals or groups. I do not provide nutritional counseling in either health or disease that is a dietary nature. I do not develop, implement or manage systems in nutritional care, nor do I evaluate, change or maintain standards of food quality or nutrition services for individuals or groups of patients in licensed facilities, or in private office settings.

I am a registered and licensed occupational therapist, specializing in craniosacral therapy, and a certified holistic health practitioner and advocate of natural health and living. I promote the practice of healthful living for the enhancement of wellness. My bio-energetic and bio-feedback testing, recommendations of natural products and advocacy of healthy lifestyles are not substitutes for medical and/or dietary treatment of disease.

I do not practice any type of primary care mode of therapy such as a medical doctor does. For any medical nutritional/dietary problem, in all matters of total wellness and disease prevention, I highly and wholeheartedly recommend that my clients see a licensed physician and dietician regularly for a physical examination and basic blood tests, to have their doctor or dietician diagnose any medical or dietary problems or disease, and encourage that they follow their doctor's or dietician's prescribed modes of therapy according to the dictates of their own conscience. In times of illness, or in the presence of symptoms of illness, I strongly encourage all clients to seek medical attention immediately from a licensed physician.

I work in an effort to balance the energy meridians of the body, including the biological terrain and immune system. However, the implementation of any lifestyle changes or stress reduction techniques, as well as the use of natural remedies, herbs, vitamins, minerals or foods that one might use or to avoid, in an attempt to balance the body and its meridians, are not prescribed treatments or courses of therapy, but recommendations designed to stimulate the body to make such changes on its own. It is up to each individual to decide if such approaches are appropriate for them and must be based entirely upon their own free will and choice.

If you would like a copy of this policy to keep, please ask the front desk

Biofeedback Stress Response Testing/Wellness Evaluation Authorization and Release Form

1. I fully understand the difference between the practice of allopathic medicine (diagnosis, treatment and prevention or management of disease through current standards of care), and holistic health considerations (using natural approaches to optimize health and stimulate the body towards self-adjustment and balance).
2. I fully understand that Todd Stelik is not an allopathic doctor (MD) and does not claim to be, but he is an occupational therapist and bioenergetic practitioner providing services that are not allopathic, but that are within the parameters of a natural health and wellness philosophy. I have read and fully understand the Statement of Practice (see reverse).
3. I fully understand that Todd Stelik does not offer allopathic drugs, surgery, chemical stimulants, or radiation therapy, but is providing information and natural products to restore natural balance and optimum conditions for health and wellness based on the scope of his practice.
4. I fully understand that Todd Stelik is not diagnosing or treating any illness or disease, but that it is bioenergetic balance and overall stress responses of the body that are being measured.
5. I fully understand that Todd Stelik is in no way encouraging me to terminate or modify any previous or ongoing therapies started by or under the direction of any licensed practitioner.
6. I fully understand that the services provided by Todd Stelik may not be generally accepted and/or recommended by allopathic physicians or other health professionals.
7. I presently seek consultation, advice, opinions and/or programs, assessments and/or products within the scope of Todd Stelik's wellness practice based upon the principles of holistic health.
8. I have solicited Todd Stelik's services in good faith, exerting my free will and following the dictates of my own conscience which allows me to select what I understand is most beneficial to my health.
9. If I desire services not provided by Todd Stelik, I fully understand that I should seek them elsewhere, and that Todd Stelik can/will not dissuade me from seeking allopathic attention, recommendations, or modes of therapy from a licensed practitioner.
10. If a minor or an individual accompanies me who must be assisted by me in some way, either partially or completely, I give full faith that I am legally and totally responsible for them.
11. I authorize Todd Stelik and staff to provide their services to me on my behalf, and hereby release them from any claims arising out of my actions or failure to act upon their advice.
12. I give full faith that I have read and understand this document entirely, that I have received an explanation of the same and that my questions have been answered to my satisfaction regarding this form.
13. I am willing and prepared to declare and repeat the above statements under oath at the request of Todd Stelik or anyone else.

I hereby consent to and authorize the above-described evaluation and consultation:

_____ _____

Parent or Guardian Signature (if under 18) Date

_____ _____

Patient Date

_____ _____

Witness Date