



Be Well. Live Well.

1470 East Valley Road, Suite M
Santa Barbara, CA 93108
Tel: (805) 565-5252
www.bissellclinic.com

Patient Information

Patient Name : _____ Email : _____

Address: _____ City/State/Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Social Security No: _____ Birth Date: ____/____/____ Age: _____

Gender: [m] [f] Marital Status: _____ Spouse's Name: _____

Emergency Contact: _____ Phone: _____

Are you interested in building muscle? YES NO

How did you hear about us? Google Yelp Mailer Facebook/Instagram Print Ad

Patient: Name of person that referred to our office: _____

Employer Name & Phone: _____

Primary Care Physician Name & Phone: _____

May we contact your primary care physician? YES NO

Physical Therapy Patients with MEDICARE, please answer the following:

Are you receiving or have you recently received home health services? YES NO

Have you received other physical therapy services this year ? YES NO

2025

Bissell Clinic Consents & Office Policies

Financial/Office Policies: I understand and agree to the following policies implemented by Bissell Clinic:

- Payment is expected when services are rendered unless prior arrangements have been made.
- **48-hour notice of cancellation is required to avoid a charge for the missed appointment.**
- **24-hour notice (or less) of cancellation will result in the full fee charge for the missed appointment.**
- A \$50.00 service fee will be imposed for all checks returned for insufficient funds. Bissell Clinic will only submit claims to Medicare for patient reimbursement as a non-par provider. We can provide a *superbill* if you would like to submit to insurance for reimbursement. We recommend confirming you have out of network benefits.
- A 3.95% surcharge for all credit card transactions. This surcharge excludes Medicare, HSA and FSA patient payments.
- All accounts that are delinquent at 60 days are subject to a \$25 penalty and will be charged \$15 per bill, per month thereafter. Accounts will be reported to the credit bureau for collection at 90 days and charged a \$250 filing fee.

Please Initial: _____

Informed Consent: I hereby request and consent to the performance of chiropractic adjustments and procedures and/or various modes of physical therapy including stretches and exercises, performed on or by me (or on the patient named above, for whom I am legally responsible) by Dr. Bissell, Dwight Hank Peterson, P.T., Kimberly Courtney, D.P.T., Gerry Perez, D.P.T. and/or those working at the clinic.

I recognize that all health care procedures, including those used in this office, have risks associated with them. Risks, although rare, associated with chiropractic adjusting procedures may include minor aggravation of symptoms, musculoskeletal sprain/strain, neurological deficits, osseous fracture, vertebral artery syndrome and stroke or death through complicating factors. Physical Therapy exercises and stretches may result in muscle soreness. I do not expect the doctor to be able to anticipate and explain all risks and complications and wish to rely on the doctor to exercise judgment during the course of the procedure, which the doctor feels at the time, based upon the facts then known, is in my best interests.

I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. I hereby accept the risks associated with any care by the doctor, therapists, and their assistants and release Bissell Clinic of any liability for any injury or loss directly related to care I have received at this clinic.

Please Initial: _____

1470 East Valley Road, Suite M
Santa Barbara, CA 93108
Tel: (805) 565-5252
www.bissellclinic.com

Authorization of Payment: I hereby directly authorize Bissell Clinic the release of any medical records necessary to facilitate my treatment to process Medicare claims and otherwise permitted or required in the Notice of Privacy Practices. I understand fully that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment. I promise to pay legal interest on indebtedness, together with such collection costs and reasonable attorney fees (Civil Code 1717) as may be required to affect collection.

I further understand that any charges incurred for services rendered by an ancillary provider, radiology facility, or another chiropractor or physical therapist as a result of a referral made by Bissell Clinic may or may not be reimbursable depending on that clinic's contracted status with my insurance company. I realize that it is my responsibility to check this information prior to consenting to the procedure or treatment.

You are responsible for payment at the time of service. If you prefer, you may leave your credit card on file. By initial below, you are authorizing us to make current and future charges to your card.

Please Initial: _____

Treatment of Minors: I, as parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so. I authorize Gerry Perez, D.P.T., Dwight Hank Peterson, P.T., Kimberly Courtney, D.P.T., & /or whomever they may designate as their assistant to administer treatment as deemed necessary.

Please Initial: _____

Treatment Acknowledgment and Disclaimer: I acknowledge that I am receiving a complimentary or demonstration treatment of Emsculpt Neo, Emsella, and/or ExoMind at no cost. I understand that these sessions are provided for educational and promotional purposes and are not a substitute for a full treatment series or medical diagnosis. I confirm that I have disclosed all relevant medical history and conditions to the best of my knowledge. I understand that results may vary and that no guarantees are made regarding outcomes. I release the provider and clinic from any liability related to these demo treatments and consent to receive the treatment (s) as described.

Please Initial: _____

Consent for Medical and Marketing Purposes: By signing below, you consent to the use of photographs and/or videos taken during your visits for the following purposes:

- Medical Charting: For documentation and monitoring of your treatment and progress as part of your medical records.
- Marketing and Promotional Use: For use in social media, websites, print materials, and other promotional outlets to promote the services of Bissell Clinic.
- I consent to the use of my photographs and/or videos for both medical charting and marketing purposes as described above. I understand these images may be used in my medical records and may also appear in marketing materials, including social media and advertisements.

Please Initial: _____

Notice of Privacy Practices: Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosure for the purpose of treatment, payment or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures. Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment. You may inspect and receive copies of your records within 30 days of a written request to do so. There may be a reasonable cost-based fee for photocopying, postage & preparation. You may request changes to your records. Our practice has the right to accept or deny your request. We maintain a history of protected health information disclosures that is accessible to you. In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff. Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office. You may file a complaint about privacy violations by contacting our Office Manager.

I acknowledge receipt of the Notice of Privacy Practices.

Please Initial: _____

I certify that all the information provided herein is true & correct.

Patient Signature: _____ Date: _____