INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

John & Judy Soborowicz, DC CCN   Active Health 3521 London Rd   715-834-6333

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: physical examination, tests, diagnostic x-rays, physio therapy, physical medicine, physical therapy procedures, etc.on me by the doctor of chiropractic named above and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Homers' syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss the nature, purpose and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

If there is any dispute about my care, I agree to a resolution by binding arbitration according to the American Arbitration Association guidelines.

I have read (or have had read to me) the above explanation of the chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future conditions(s) for which I seek treatment.

NUTRITIONAL INFORMED CONSENT

According to the Federal Food, Drug and Cosmetic Act, as amended, Section 201 (g) (1), the term “DRUG” is defined to mean:

“Articles intended for the use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease.”

A vitamin is not a drug, NEITHER is a Mineral, Trace Element, Amino Acid, Enzyme, Herb, or Homeopathic Remedy.

Although a Vitamin, a Mineral, Trace Element, Amino Acid, Enzyme, Herb, or Homeopathic Remedy may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented, or be classified as a drug by anyone.

Therefore, please be advised that any suggested nutritional advice or dietary advice is not intended as any primary treatment and or therapy for any disease or particular bodily symptom.

Nutritional counseling, vitamin recommendations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the physiological and biomechanical processes of the human body.

Nutritional advice and nutritional intake may also enhance the stabilization of the eight (8) chemical components of the VSC (Vertebral Subluxation Complex).

We do not accept insurance for* nutrition *services as it is rarely covered or reimbursed.

I hereby give my consent for photos of myself, taken by staff, to be used by Active Health in promotional and advertising capacities.

SIGN ONLY AFTER YOU UNDERSTAND AND AGREE TO THE ABOVE

____ Date:______________

Patient's or Guardian's Signature

______________________________ MR#:____________

Witness

Financial Policy

We understand the cost of healthcare is a concern for our patients. Our goal is to accurately seek the cause of your problem and treat it with the most cost effective care possible. This form is to notify you of our fees.

No Insurance / Self-Pay:

TOS: All payments made on the day the service is provided receive our **Time of Service discount of 16%.** Most common services and fees are listed below:

Progress Exam: $68.00
Nutrition Exam: $95-$260
Spine Adjustment 1-2: $39.00
Spine Adjustment 3-4: $45.00
Spine Adjustment 5: $52.00
Extremity Adjustment: $27.00
E- Stim Therapy: $27.00
Myofascial Release: $27.00
Percussion: $18.00

Family Pre-Pay: Depending on your case, you may benefit from our most affordable option, **Family Pre-Pay.**

Number of Visits	Regular fee per visit	Family Plan Fee	Discounted Price Per Visit
5	$60.00	$210.00	$42.00
10	$60.00	$390.00	$39.00
20	$60.00	$740.00	$37.00
30	$60.00	$1,050.00	$35.00

Insurance:

As a courtesy to you our clinic will submit your insurance claims. You should know any limits, co-pays, or deductibles, which apply to your policy as they affect your reimbursement and the portions you are responsible for. **We strongly encourage you to call your provider and know your policy limits and pay any copay or partial portion.**

Insurance response to billing varies from 4 to 6 weeks. Be aware, you may be accumulating fees during this time, which you are responsible for. You will not receive a bill from Active Health billing services until your insurance carrier has processed charges.
While we do what we can to assist you with your insurance billing, your contract for reimbursement is between yourself and your carrier.

Some insurance plans have very high deductibles. If you chose not to use your insurance, we provide cost effective Self-pay options, including our **Family Pre-Pay.**

Medicare:

As a courtesy to you, our office will submit your Medicare and/or Secondary Insurance claim. If you carry a secondary insurance they may participate with fees associated with your care. Medicare payments are sent to your home, please open and read your correspondence from Medicare. Checks written to you are your reimbursement for payment you have made to our clinic. To insure timely billing please bring any insurance paperwork associated with your care to our clinic

If you have a policy that covers only what Medicare covers, and you need additional services you may benefit from self-pay options. **If you have a Medicare Replacement plan, we strongly encourage you to call your provider for policy limits.**

_____ Medicare will send checks to your home for the services you receive at Active Health. Payments for services are due at the time of service.

_____ Please bring in any paperwork you receive from Medicare and/or your secondary insurance.

Understand your charges and responsibility financially associated with your care, and know that any fees for services not reimbursed are your responsibility.
Balances not paid at the time of service will be billed to your current address. These will be due in full each month. Balances not paid within 6 months and/or after conclusion of your care will be sent to collections.

Signature ______________________________ Date ______________ MR#__________