

Authorization of Care

I hereby authorize Dr. Philip Que and staff to work with my condition through the use of methods within the Chiropractic scope, as he deems appropriate. I clearly understand and agree that all services rendered me are charged directly to me, or billed to my insurance carrier. I agree that I am ultimately responsible for all fees and bills incurred at this office. In the event that my insurance carrier does not reimburse Active Living Chiropractic LLC for professional services performed, I understand that I will be billed for all fees outstanding. Active Living Chiropractic LLC will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable.

I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to Active Living Chiropractic LLC, for services rendered. I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself, and that Active Living Chiropractic LLC will not be a mediator.

Ownership of X-ray Films: *It is understood and agreed that the payments (if applicable) to Active Living Chiropractic LLC for X-rays are for the information and examination on the X-rays only. The x-ray negatives will remain the property of Active Living Chiropractic LLC.*

Signature: _____ Date: _____

Guardian or Spouse Authorization Signature: _____

Terms of Acceptance

When a patient seeks chiropractic care and we accept such a patient for care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is only when the patient understands both the objective and the method that they will be able to attain it. This will prevent any confusion or disappointment.

An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxations. Our chiropractic method of correction is by specific adjustments to the spine.

Health is a state of optimal physical, mental and social well-being, not merely the absence of sickness or disease.

Vertebral Subluxation is a misalignment of one or more of the joints of the body. This can cause pain or alteration of nerve function and interference of the transmission of nerve impulses, lessening the body's innate ability to maintain maximum health.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care

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provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom.

I have read and fully understand the above statement. Any questions regarding Active Living Chiropractic LLC's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Signature: _____ Date: _____

Notice of Privacy Policy

Protecting the privacy of your personal health information is important to us. 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 disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- *Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.*
- *Obtain payment from third party payers.*
- *Conduct normal healthcare operations such as quality assessments and physician's certifications.*

I have read and understand your Notice of Privacy Policy. A more complete description can be requested. I also understand that I can request, in writing, that this office restrict how my personal information is used and or disclosed.

Signature: _____ Date: _____

Guardian or Spouse Authorization Signature: _____

Active Living Chiropractic

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