

## TERMS OF ACCEPTANCE

**VERTEBRAL SUBLUXATION:** A misalignment of one or more of the 24 vertebra in the spine, or within the extremities, which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral and extremity subluxation. However, if during the course of a chiropractic spinal examination, 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 provider who specializes in that area.

**\*\* Possible Adverse Reactions to an Adjustment:**

**Soreness:** I am aware that like exercise it is common to experience muscle soreness in the first few treatments.

**Dizziness:** Temporary symptoms like dizziness and nausea can occur but are relatively rare.

**Fractures/Joint Injury:** I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disk, or other abnormality is detected, this office will proceed with extra caution.

**Stroke:** Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in one million to once in ten million treatments.

I, \_\_\_\_\_ *have read and fully understand the above statements.*  
(Print Name)

*All questions regarding the doctor's objectives pertaining to the care in this office have been answered to my complete satisfaction.*

*I, therefore, accept chiropractic care on this basis.*

\_\_\_\_\_  
(Signature)

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

## HIPPA Regulations Natural Elements will Follow to Ensure your Protection

### Your Rights

- The right to request restrictions on certain uses and disclosure of your protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree to a requested restriction.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.

### Electronic Billing is Sent through E-Claims, Inc.

In 2009 all healthcare professionals are required by law to send their bills, correspondence, and related billing information electronically. Natural Elements uses the billing services of E-Claims, Inc., a company also required to follow HIPPA regulations noted by the Dept. Of Health and Human Services (federal level). Information that will be electronically submitted is:

*Beneficiary's name, date of birth, address, Beneficiary's health insurance identification and claim number, Date(s) of service, Diagnosis/nature of illness, Procedure/services performed*

### Contact Information

If you think your privacy rights have been violated by us, or disagree with a decision we made about access to your personal health information, you may contact:

The U.S. Department of Health & Human Services  
Office of Civil Rights  
200 Independence Ave. S.W.  
Washington, D.C. 20201  
(202) 619-0257

Toll Free: 1-877-696-9775

I have received a read copy of the notice of privacy practices. This acknowledgement applies to:

Print Name \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

## FINANCIAL POLICY

**Release of Information:** My signature below authorizes Natural Elements Health Center, Inc., it's employees, and/or agents to release any information concerning my health and healthcare services to my insurance companies, pre-paid health plan or Medicare. I authorize the use of the signature below and all insurance submissions.

**Assignment of Insurance Benefits:** In addition, I also authorize and direct that payment for services rendered be made directly to Natural Elements Health Center, PC or Dr. Christine Schlenker.

**Payment Agreement:** It has been explained to me and I understand, that there is no guarantee that my insurance companies or pre-paid health plan will cover or pay for any or all of my charges. Notwithstanding denial, medical necessity, denial of treatment plan, reduction of benefits, or failure to pay for any reason, I understand that I am responsible for all expenses incurred for professional services rendered. My signature shall remain in force whenever treatment is required and/or rendered by Natural Elements Health Center, PC. employees or agents. Overdue accounts are also liable to legal and collection fees.

**If I Do Not have insurance,** all payments are expected at the time of service or by an authorized payment plan. Our payment plans make care an affordable part of your family budget.

**If I Have insurance, All deductibles and co-pays** are expected at the time of service or by an authorized payment plan. \*\*Note: You are considered a cash/non-insurance patient until you bring in your completed insurance forms, and we qualify and accept your insurance. Our fees are considered usual, customary, and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area. If your insurance carrier has not paid a claim within 60 days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within 90 days of submission, you accept responsibility for payment in full of any outstanding balance.

**Returned Check Policy:** All returned check's will be a \$30.00 non-sufficient funds charge.

**Signature of Patient:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

### Select Patients Only

**I understand that I have refused the examination to diagnose the cause of the problem and will only be checked for a safe spinal adjustment. The only diagnosis I will receive is for a standard spinal adjustment. I have the right to an examination at a later time if I so chose.**

**Signature of Patient:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

#### \*\*For Doctor Use Only\*\*

##### PATIENT STATUS AT TIME OF INFORMED CONSENT AND TERMS OF ACCEPTANCE PROCESS

Based on my personal observations, medical history and direct conversation with the patient, I conclude that throughout the consent process the patient was:

- |     |   |     |              |     |                    |
|-----|---|-----|--------------|-----|--------------------|
| [ ] | Of legal age  | [ ] | Oriented x 3 | [ ] | Coherent and lucid |
| [ ] | Proficient in understanding the English language                        |     |              |     |                    |
| [ ] | Assisted in understanding by an interpreter (Interpreter's name: _____) |     |              |     |                    |
| [ ] | Unable to give legal consent  |     |              |     |                    |
| [ ] | Consent given thru legal guardian _____                                 |     |              |     |                    |

Name

Relationship

I certify that the above accurately describes the above named patient's status during the informed consent process.

Date \_\_\_\_\_

Signature of Doctor \_\_\_\_\_