

# Policies and Consent

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## Terms of Acceptance

Welcome to our office, we are glad you are here! When a patient seeks chiropractic health care, and we accept a patient for such care, it is essential for both parties to be working towards the same objective.

It is important that each patient understand both the objective and the method that will be used to attain it. This understanding will prevent any confusion or disappointment.

- **Correction** - A correction is the specific application of forces to remove a misalignment found in the spine.
- **Health** - A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.
- **Vertebral Subluxation** - A misalignment of one or more of the 24 vertebrae in the spinal column, 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 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.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Chiropractic has only **ONE** goal. Our only practice **OBJECTIVE** is to eliminate a major Interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

## Insurance

We are currently only a participating provider (PPO) with BCBS-IL, however we will assist in completing the proper forms for you to be reimbursed from other providers. Reimbursement for covered services from other carriers will be sent to you directly from your insurance company. BCBS members will pay any co-pays and deductibles that are due at the time of service.

## Medicare

Our office is a non-participating provider for Medicare. Any charges for the office visits will be paid at time of service unless otherwise noted and TLC will submit the billing to Medicare for the patient to be reimbursed. If you do have a secondary insurance carrier, Medicare will submit to them directly. Medicare and the secondary provider will typically cover **ONLY** the adjusting fees and **NOT** any exams, x-rays or non-adjusting office visits.

## Workers Compensation/Personal Injury/Motor Vehicle Accident.

We welcome you as a patient, however we do not file or accept WC/PI/MVA Insurance unless it is direct/med- pay. Not all care received at TLC is covered by WC/PI/MVA. Please refer back to your employer/policy for further coverage information.

## X-Rays

X-rays taken in our office are the property of Tree of Life Chiropractic, Inc. The fees charged for the x-rays are for the reading of the x-rays only. Copies of your x-rays can be obtained for a charge of \$5.00 per film. Please notify us one week in advance for your x-ray duplication needs.

## Missed Appointment

In order to provide all of our patients with the best care possible, please call if you are unable to keep your appointment. We will gladly reschedule your appointment. If you are more than 15 minutes late for your appointment, we may need to reschedule for a different time. We reserve the right to charge for the time reserved, if necessary.

**Fees and Charges**

- Adjusting visits will be billed directly to Medicare and to Blue Cross Blue Shield
- Re-x-ray charges: There will be no charge for follow-up x-rays in the first year. However, if your spinal misalignment changes due to a new injury/trauma, surgery or auto accident, there will be a charge for new x-rays.
- If new x-rays are necessary after the first year, there will be a charge of \$30.00 per film to a yearly maximum of \$150.00.
- Services other than those provided on routine visits may be charged separately.

**Acceptable Forms of Payment: Cash, Check, VISA, Master Card or Debit. I am responsible for payment of all charges.**

<b>Establishing a New Patient</b>	<b>Child/Adult</b>	<b>Infant &lt;4m</b>
History/Examination	\$45-80	\$45
Report of Findings	\$35-50	*
Pre / Post Cervical X-rays	\$75 / 50	*
<b>TOTAL</b>	<b>\$205-255</b>	<b>\$45</b>
*Initial standard protocol, however case may need radiographic studies if indicated. Total fee may be adjusted due to time needed for additional exams.		

**Common Daily Cash Fees**

Routine Spinal Examination	\$30
Extremity Evaluation and Correction	\$25
Progressive Evaluation	\$40
Spinal Correction (Adult/Child*)	\$50/35
Senior Exam and/or adjustment	\$35
Day 1 Cash Total	\$120
Day 2 Cash Total	\$100 + Adj

*\*Child without complicated issues.  
-Insurance charges do not reflect cash discount*

**PATIENT CONSENT**

Please Initial Below

**Acceptance of Care:**

I authorize Tree of Life Chiropractic, Inc. to administer chiropractic care.

**Insurance Processing:**

I authorize Tree of Life Chiropractic, Inc. to release any information of office record necessary to help process insurance claims.

**Radiographic Imaging:**

I have been informed by Tree of Life Chiropractic, Inc. that x-rays are advisable in my case so that a complete analysis can be made of my present spinal condition.

I authorize Tree of Life Chiropractic, Inc. to perform such radiographs examinations necessary to analyze and administer proper care as is deemed necessary to treat my present condition.

**Females Only:**

To the best of my knowledge, I am **NOT** pregnant and the Doctor has my permission to x-ray me for obtaining information necessary to my case.

or

I **AM** pregnant and the Doctor has my permission to x-ray me using a lead apron.

**Care of a Minor:**

I authorize Tree of Life Chiropractic, Inc. to adjust my child and perform any necessary tests to determine the condition of his/her spine.

Name of Minor: \_\_\_\_\_

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

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. Fees are payable when services is rendered unless other arrangements have been made in advance. Fees are subject to change without notice.

I therefore accept chiropractic care on this basis.

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Tree of Life Chiropractic  
Rock Island, IL  
Fulton, IL

\_\_\_\_\_  
(patient signature)

\_\_\_\_\_  
(date)

Updated 6/2015