Londos Family Chiropractic

7006 Huntley Road, Carpentersville, IL 60110 Telp.(847) 836-7101 Fax. (847) 836-7047

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

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

Adjustment: An adjustment is the specific application of force to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of 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 vertebra 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 it's 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 a 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. **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.

I _____ have read and fully understand the above statements.

All questions regarding the doctor'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 _____

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STATEMENT OF FINANCIAL RESPONSIBILITY

In consideration for the services rendered by the doctors at Londos Family Chiropractic ("Londos"), Patient will pay at the time services are rendered or Patient will make financial arrangements satisfactory to Londos. If Patient's insurance or health plan designates for co-payments, co-insurance or deductibles, Patient agrees to pay them to Londos. All service balances are due and payable at the time of service. If payment is not received, Londos reserves the right to refuse future appointments on delinquent accounts.

Insurance: Insurance is a contract between you and your insurance company. You will need to pay any and all of your coinsurance and co-payments at the time of service. If you choose to pay for all of your treatment in full at time of service, we will promptly issue a refund or credit your account for future care for any credit balance. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by them. It is the responsibility of the patient to verify with your insurance and/or pre-authorization, it is your responsibility to obtain and provide it to our office. Failure to obtain the referral and/or pre-authorization may result in a denial from the insurance company, and the balance will be your responsibility.

Medicare: Londos is a participating provider with Medicare Part B. Londos agrees to bill and accept contractual adjustments from Medicare. There may be services and supplies rendered in the office that are not covered by Medicare and therefore require an Advanced Beneficiary Notice ("ABN") be signed by the patient/Guarantor. By signing the ABN, it is understood that Patient is financially responsible for payment of any services and/or supplies that are not deemed medically necessary by Medicare.

Monthly Statement: If there is a personal patient balance on the account, Londos will send Patient a monthly statement. Patients are responsible for all charges resulting from treatment provided at Londos. Payment is due within 30 days of receipt of this statement, unless other financial arrangements have been made with the office manager.

Past Due Accounts: Patient understands and agrees that if his/her account is delinquent past 90 days without financial arrangement with the office manager, Partient may be turned over to the collection agency used by Londos.

Returned Checks: There is a fee of $ 35.00 on any checks returned by the bank due to non-sufficient funds or otherwise.

After Hours Policy: If there is a chiropractic emergency' after office hours, there is a $ 20.00 fee that is payable at the time of service. This fee is not billed or paid by your insurance company if applicable. This fee is in addition to and separate from any chiropractic adjustment fees, co-payments, co-insurance or deductible that you may owe.

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STATEMENT OF FINANCIAL RESPONSIBILITY

Court Costs and Attorney Fees: In all actions or legal proceedings to enforce any part of this agreement, the prevailing party shall recover attorney fees and court costs.

Severability: If any portion of this agreement is held to be invalid by a court with proper jurisdiction, its invalidity will not affect the validity or enforceability of any other provision of this agreement.

Force Majeure: If Doctor is prevented from completing performances of any obligations contained in the agreement by any act of God, strikes, epidemics, war, acts of terrorism, riots, flood, fire, hurricane, tornado, sabotage, or other occurrence which is beyond the control of the parties, then Doctor shall be excused from any further performance of obligations or undertakings contained in the agreement, to the full extent allowed under applicable law.

Modification: Any modifications to this agreement must be in writing signed by Doctor and Patient.

Governing Law: Illinois law governs this agreement.

Venue: The parties agree that the venue for any dispute arising out of this agreement will be The 22nd Judicial Circuit (Second Appellate District), Woodstock, Illinois.

Merger: This document, along with the Londos Family Chiropractic Insurance Assignment Agreement and the Informed Consent to Chiropractic Acknowledgement contain the entire agreement between the parties, and no promises or representations, other than those contained here and those implied by law, have been made by Doctor or Patient.

I have read the above provisions and agree to abide by the provisions as specified above.

_____ _____

Patient's Signature Date

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INSURANCE ASSIGNMENT AGREEMENT

We have put our financial policy with regard to insurance assignment into writing so that there is no misunderstanding regarding our fees and the payment process associated with your chiropractic care in our office. Please feel free to discuss this policy with us at any time. It is the policy of Londos Family Chiropractic ("Londos") to have a financial policy that clearly outlines patient and practice responsibilities. We are committed to providing our patients with the best possible chiropractic care while minimizing administrative costs.

1. Waiting for insurance payment is a courtesy and may be withdrawn at any time.

2. Payment for your initial consultation and examination in full at the time of service regardless of insurance coverage unless you have made payment arrangements in advance.

3. It is important that you understand your plan coverage. While we verify all insurance plans. You should call your carrier and be sure that you understand your coverage as well.

4. We will gladly submit your claims and work with you and your insurance carrier. You will be notified when your insurance reimbursement goes beyond 45 days without payment to contact your insurance carrier to request payment. After 90 days, you will be billed and we will expect payment, or payment arrangements, from you.

5. If we do not participate in your insurance program or your program does not allow assignment of benefits to your doctor, you will be responsible for all charges.

6. Some insurance companies send payment directly to the patient/insured only. If you receive a check from the insurance carrier on an assigned claim, you must bring the check and the attached Explanation of Benefits (EOB) page to our office so we can properly credit your account.

7. We do not have payment plan options. These options will be discussed with you at your Report of Findings and may be entered into at any point in your chiropractic care.

8. If you do not have, or lose insurance coverage, payment options can be discussed with you and payment arrangements can be made prior to initiating care.

9. Any service that is not covered by your insurance is your responsibility. This may include examinations, x-rays, tractioning, exercise blocks and supports, and any other service we perform. Payment for non-covered services is due at the time of service or upon notification from your insurance carrier that the service is not covered under your plan.

10. If, at any time, payment issues interfere with your ability to receive chiropractic care, please arrange for a time to speak privately with the staff or the doctor to arrange for your continued care.

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INSURANCE ASSIGNMENT AGREEMENT

We hope that these policies answer some of your questions regarding your insurance coverage and how they may apply to your chiropractic care here at Londos Family Chiropractic.

I, _____ have read the above Assignment Agreement. I understand the terms of this agreement and accept them in consideration of utilization of my insurance benefits.

_____
Date

_____
Signature

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INFORMED CONSENT TO CHIROPRACTIC ACKNOWLEDGEMENT

I hereby request and consent to the performance of chiropractic manipulation and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays by Aaron Londos, D.C., licensed by the State of Illinois Board of Chiropractic.

Though chiropractic manipulation and/or associated therapeutic or diagnostic procedures are usually beneficial and seldom are associated with negative or adverse side effects, I understand that some risk to treatment may be possible. Some risks may include, but are not limited to, unintended fracture, cervical/thoracic/lumbar disc injuries, possible stroke, facet joint dislocations, and muscle or ligament strain/sprain. Certain topical analgesics that might be applied may contain chemicals that might be sensitive for some individuals.

I understand that chiropractic, as a professional service, is not an exact science and that, therefore, reputable practitioners of chiropractic cannot fully guarantee desirable results. Our treatment protocols are based upon clinical experience and research, and every available option for care is considered when our doctor makes his recommendations. Full compliance with these recommendations will increase the likelihood that you may experience positive and/or desirable results. If you, at any time, would like to explore other options for care, please mention this to Aaron Londos, D.C., and he and you can formulate a collaborative care plan to fit your healthcare needs.

Based on these informed consent statements, I have had the opportunity to read this form and ask any necessary questions. My questions have been answered to my satisfaction, and I consent to the proposed treatment.

Patient name (please print): _____

Signature of Patient: _____

Signature of Witness: _____

Doctor Signature:
_____

Date:
_____

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EMERGENCY CONTACT SHEET

Patient's Name _____

1st Contact _____
Address _____
_____
Phone _____

2nd Contact _____
Address _____
_____
Phone _____

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HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT

Consent for Purposes of Treatment, Payment and Healthcare Operations

I acknowledge that **Londos Family Chiropractic's** "Notice of Privacy Practices" has been provided to me.

I understand I have a right to review Londos Family Chiropractic's Notice of Privacy Practices prior to signing this document. Londos Family Chiropractic's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Londos Family Chiropractic. The Notice of Privacy Practices for Londos Family Chiropractic is also provided on request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and Londos Family Chiropractic's duties with respect to my protected health care information.

Londos Family Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority