Active Health
Chiropractic Clinic
Dr. Erik M. Fotheringham

Phone: (248) 922-3334
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ACKNOWLEDGMENT OF RECEIPT OF OFFICE PRIVACY POLICY

I acknowledge that Active Health Chiropractic Clinic's *Notice of Privacy Policies* has been provided to me. I understand that I have a right to review Active Health Chiropractic Clinic's *Notice of Privacy Policies* prior to signing this document.

The *Notice of Privacy Policies* 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 performances of health care operations of Active Health Chiropractic Clinic and is also provided on request at the main administration desk of this practice. This *Notice of Privacy Policies* also describes my rights and Active Health Chiropractic Clinic's duties with the respect to my protected health information.

Active Health Chiropractic Clinic reserves the right to change the privacy practices that are described in the *Notice of Privacy Policies*. I may obtain a revised notice of privacy policies by calling Active Health Chiropractic Clinic and requesting a revised copy to be sent in the mail or by asking for one at the time of my next appointment.

CONSENT FOR TREATMENT AND X-RAY POLICY

It is understood and agreed upon that the amount paid to Active Health Chiropractic Clinic for x-rays is for examination only, and the x-ray negatives will remain the property of this clinic, being on file where they may be seen at any time while being seen as a patient of this clinic. The patient also agrees he/she is responsible for payment for all bills incurred at this clinic (x-rays are non-transferable). Medical records and reports may be requested with a 24-hour advance notice.

It is the doctor's discretion up review of x-rays that any unusual findings will be sent to an additional specialist as a precautionary measure for a fee of $50. A copy of this report will be available to the patient.

TERMS OF ACCEPTANCE

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.

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

<u>Adjustment:</u> The specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

<u>Health</u>: A state of optimal physical, mental and social well-being, not merely the absence of disease.

<u>Vertebral Subluxation:</u> A misalignment of one or more of the 24 vertebra on the spinal column which causes alteration of the 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 the vertebral subluxation. However, if during the course of the 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. 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.

Please note that massage cancellations with less than 24-hour notice will result in a $40 cancellation fee ($80 fee for two-hour massage).

I,_____, hereby authorize Dr. Erik M. Fotheringham and whomever he may designate as his assistants to administer treatment as he deems necessary to myself 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**_____

Witness _____ **Date**_____