

**North Shore Pro-Active Health Office Policy p.1/2**  
**112 W. Lake St. Libertyville, IL 60048**  
**847-362-4476 www.DrLeasure.com**

We believe that a clear definition of our office policies will allow both you, the patient, and us, the doctor, to concentrate on the big issue ~ **REGAINING AND MAINTAINING YOUR HEALTH.**

**APPOINTMENT POLICY**

Multiple appointments have been scheduled, for your convenience, to minimize waiting and to facilitate incorporating these appointments into your daily routine.

Regardless of how many appointments are scheduled for you each week please note it is the frequency of the visits that counts and not the specific days. Therefore, if you are unable to keep an appointment for any reason, call immediately to reschedule your visit.

The office reserves the right to charge \$40 for missed appointments not cancelled with a 24 hour notification. A cancellation at the time of a reminder call does not justify proper notice.

**SCHEDULING**

We attempt to honor all appointments at the scheduled time. If you are late, you may have to wait for the next available appointment. Please arrive 10 minutes before scheduled time for any massage appointments.

**X-RAY & RECORD POLICY**

The x-rays that are taken are the property of NSPAH. Release for purposes of review can be arranged at your request with at least 24 hours notice.

**FEES CHARGED**

All fees are based upon individual services rendered, and may vary from visit to visit depending upon the recommendations.

**WELLNESS OPTION**

For those patients who are uninsured or under insured we offer payment plans & ChiroHealth USA to make care affordable. The EMT program is all-inclusive & available for a low monthly fee.

We offer many options for payment plans. It is the policy of this office to keep a credit card or checking account number on file. Please choose which one you would prefer.                      Check                      \*Visa                      \*MasterCard

Account Number last 4 digits \_\_\_\_\_

Exp. Date \_\_\_\_\_

Card Holder Signature \_\_\_\_\_

By signing below I acknowledge that I have read, understand and agree to the terms of the office and financial policies of North Shore Pro-Active Health.

Patient Name/Signature \_\_\_\_\_

Date \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

Witness Signature \_\_\_\_\_

Date \_\_\_\_\_

**OFFICE POLICIES**

**NO CELL PHONES!!** Due to the nature of the office, equipment interaction and HIPAA regulations we request that any phone calls be taken outside. No text messaging, pictures of the office, etc. may be engaged in while within NSPAH.

Due to the open layout of the office if you would like to discuss personal or private information with the doctor or staff please don't hesitate to request a private room. You may also email us at any time if a situation arises you wish to discuss privately.

It is our mission to educate and adjust as many families as possible toward optimum health through natural Chiropractic care. We routinely offer seminars, New Patient Orientations, and health talks/programs in the evenings. Please see our website for a schedule of events – some fees may apply but most events are open to the public free of charge.

**WORK COMP & PI**

Our office does accept work comp and personal injury cases. However, it is not considered work comp or personal injury until we have all insurance information, a claim number on file and liability is accepted.

**OTHER**

It is our policy that all services rendered in this office are charged directly to you, the patient, and that you are responsible for all payment, regardless of whether or not this office accepts insurance assignment.

There is a \$10 service charge for all accounts that are not paid at the time of service. A \$40 fee will be assessed for appointments missed & not cancelled with 24 hours notice. There is a \$25 NSF fee charged on all returned checks. All accounts over 90 days are turned over to collections.

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**NOTICE OF INFORMATION PRACTICES**

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 disclosures.

You may inspect and receive copies of your records within 30 days of a request. There may be a reasonable cost-based fee for photocopying, printing, postage and preparation.

You may request changes to your records. Our practice has the right to accept or deny your request. We maintain a history of PHI disclosures that is accessible to you.

We may contact you for appointment reminders, announcements, and to inform you about our practice and its staff. This may be done by phone, mail or email. We have the right to contact you and leave messages at all outlets made available to us.

**INSURANCE OPTION**

Our fees are considered usual, customary and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier.

In order for us to bill insurance for your services we must obtain a copy of your insurance card and drivers' license. We will call to verify benefits, but verification is **NOT** a guarantee of payment. When your schedule of visits is once/month or longer you are no longer eligible for insurance assignment.

All deductibles, co-pays and co-insurances are due at the time service is rendered. We will not bill for said items. We offer insurance seminars, please attend & become familiar with your policy, exclusions & limit details.

Any insurance checks that you receive are to be promptly turned over to our office to be applied to your account. Any portion of your bill that the insurance company fails to pay is 100% your responsibility. Any insurance balance over 60 days automatically becomes patient responsibility. Any patient balance over 30 days will be charged to the account on file.

By signing below I acknowledge that I have read, understand and agree to the terms of the office and financial policies of NSPAH.

**INFORMED CONSENT FOR EXAM & TREATMENT**

I consent to the performance of examination and treatment on me or on \_\_\_\_\_ by the licensed doctors of chiropractic, medical doctors, chiropractic assistants and/or licensed therapists who may be employed by or engaged in practice at NSPAH.

I have had the opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment. I understand that neither Chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses their judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interests.

I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which includes rarely, but not limited to fractures, disc injuries, strokes, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read this information and understand as it pertains to my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

**FEMALE PATIENTS**

By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. If this status changes I will immediately notify the doctor and staff as it may change treatment protocols.

To be avoided: Exposure to X-rays, Electric Muscle Stimulation or Ultrasound.

Date of last menstrual period: \_\_\_\_\_

Patient Name/Signature \_\_\_\_\_

Date \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

Witness Signature \_\_\_\_\_

Date \_\_\_\_\_