

THIS OFFICE DOES NOT ACCEPT INSURANCE

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate care, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he deems appropriate through use of Chiropractic adjustments throughout my spine. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

Patient's Signature **X** _____ Date _____

Guardian or Spouse's
Signature Authorizing Care _____ Date _____