

**CHIROPRACTIC PATIENTS ONLY**

Name \_\_\_\_\_ Date \_\_\_\_\_

Health Insurance \_\_\_\_\_

Does your policy have coverage for Chiropractic services? \_\_\_\_\_

If yes, please give our receptionist your insurance card to copy.

**Authorization and Assignment**

I authorize \_\_\_\_\_ to provide care for the examination and treatment of my case.

I authorize the release of any information necessary to my insurance provider, attorney or adjuster, as needed to process my claims.

I understand I am expected to pay for services tendered unless special arrangements have been made in advance, and I am ultimately responsible for all charges incurred, including any collection efforts or court fees.

I assign payment to be made directly to **Complete Chiropractic & Bodywork Therapies** for services billed to my insurance that are outstanding.

**Cancellation Agreement**

It is essential that 24 hours notice be given if you are unable to keep your scheduled appointment. We reserve the right to charge for missed appointments.

**Consent to Treat a Minor**

I hereby authorize the doctor to treat my son or daughter.

Name of child: \_\_\_\_\_

Name of Parent/Guardian: \_\_\_\_\_

I hereby consent to any statements stated above, that apply to my situation. Copies of these statements are as legal and binding as the original.

Signature: \_\_\_\_\_

Additional authorization for care:

Practitioner & Date of Authorization \_\_\_\_\_