

PREGNANCY RELEASE

IT IS YOUR OBLIGATION TO INFORM OUR OFFICE OF ANY POSSIBILITY OF YOU BEING PREGNANT. I HEREBY ADVISE YOUR OFFICE AND PHYSICIANS THAT I AM NOT PREGNANT AS OF THIS DATE. I FURTHER AGREE AND RELEASE YOU AND YOUR STAFF FROM ANY RESPONSIBILITY FOR INJURY OR COMPLICATION TO MYSELF OR MY FETUS SHOULD I BE PREGNANT. I FURTHER AGREE TO NOTIFY THIS OFFICE IN WRITING DURING THE COURSE OF MY TREATMENT SHOULD I BECOME PREGNANT.

Signature: _____ Date: _____
(Patient or Guardian)

AUTHORIZATION FOR EXAMINATION AND/OR TREATMENT

I, THE UNDERSIGNED, A PATIENT IN THIS OFFICE HEREBY AUTHORIZE THE DOCTOR (S) OF THIS CLINIC AND WHOEVER THEY MAY DESIGNATE AS ASSISTANTS TO ADMINISTER SUCH MEDICAL SERVICES AS IS NECESSARY, AND TO PERFORM SUCH PROCEDURES AS ARE CONSIDERED MEDICALLY AND THERAPEUTICALLY NECESSARY ON THE BASIS OF FINDINGS PRIOR TO AND DURING THE COURSE OF SAID TREATMENT.

I HEREBY CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE AUTHORIZATION FOR MEDICAL SERVICES. I ALSO UNDERSTAND THAT THE DOCTOR (S) WILL EXPLAIN WHY SUCH PROCEDURES ARE CONSIDERED NECESSARY, THEIR ADVANTAGES POSSIBLE CONSEQUENCES, IF ANY, AS WELL AS POSSIBLE ALTERNATIVE MODES OF TREATMENT.

I ALSO CERTIFY THAT NO GUARANTEE OR ASSURANCE HAS BEEN MADE AS TO THE RESULTS THAT MAY BE OBTAINED.

Signature: _____
(Patient or Guardian)

PAYMENT IS EXPECTED AT TIME OF VISIT

I UNDERSTAND AND AGREE THAT HEALTH AND ACCIDENT INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN AN INSURANCE CARRIER AND MYSELF. FURTHERMORE, I UNDERSTAND THAT THIS CHIROPRACTIC OFFICE WILL PREPARE ANY NECESSARY REPORTS AND FORMS TO ASSIST ME IN MAKING COLLECTIONS FROM THE INSURANCE COMPANY AND THAT ANY AMOUNT AUTHORIZED TO BE PAID DIRECTLY TO THIS CHIROPRACTIC OFFICE WILL BE CREDITED TO MY ACCOUNT UPON RECEIPT. I ALSO GIVE THIS OFFICE POWER OF ATTORNEY TO ENDORSE CHECKS MADE OUT BY ME, TO BE CREDITED TO MY ACCOUNT HOWEVER I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT.

Signature: _____
(Patient or Guardian)

UPON REQUEST, I WILL BE FURNISHED A RECEIPT FOR SERVICES RENDERED AND/OR COPY OF ANY INSURANCE BILLING THAT PERTAINS TO MY TREATMENT AT THE FRALICKER CHIROPRACTIC CLINIC, INC. I HAVE READ AND UNDERSTAND THE MATTERS SET FORTH AND HAVE ASKED ANY QUESTIONS I HAVE REGARDING THE MATTERS SET FORTH HEREIN AND THEY HAVE BEEN FULLY ANSWERED TO MY SATISFACTION. I ACKNOWLEDGE THAT I HAVE SIGNED AND RECEIVED A COPY OF THIS FORM ON THE _____ DAY OF _____.

Signature: _____
(Patient or Guardian)