

**Consent for Care, Financial Policy Agreement,
and Privacy Practices Acknowledgement for
Alternative Chiropractic Center**

Consent for Care: I, the undersigned, in consideration of Alternative Chiropractic Center's services, agree to the following terms:

I hereby grant permission to Alternative Chiropractic Center and its clinicians to perform examinations and therapeutic treatments as are considered necessary or advised for my diagnosis and treatment plan. Clinicians who treat me include, but are not limited to: medical doctors, acupuncturists, massage therapists, herbalists, nutritionists, physical therapists, rolfers, and/or chiropractors. My signature on this document serves as my consent for treatment.

Authorization to Release Information for Insurance clients: I authorize Alternative Chiropractic Center to release any information required to process a claim to any insurance company or attorney. I also authorize any insurance company or medical provider to release my medical records to Alternative Chiropractic Center for the purpose of processing my claim for benefits due. I hereby agree that a photocopy of this document is as valid and effective as the original copy.

Personal Responsibility for My Charges: I understand that I remain personally responsible for my charges, and that at any time, I can request a copy of my total charges from the office. I agree to pay the full amount of my charges to the office upon its demand. Any partial payments toward my charges shall be not acceptance of any installment payment plan, and shall not constitute a waiver of Alternative Chiropractic's right to receive payment in full upon demand. In the event that any payer denies payment or claim by an insurance company or second party, I agree that I am personally, fully, and immediately responsible for the portion of my charges denied or likely to be denied. In no event shall I hold Alternative Chiropractic Center liable in any of the above named instances.

HIPAA Notice of Private Practices: I understand I have access to the Notice of Privacy Practices and am able to review it and obtain a copy of it at my request.

Liability Agreement: I have read, understood and agree to the terms of this agreement.

Cancellation Policy: I agree to give 24 hours notice of cancellation and will be charged \$30.00 for services allotted if I do not show for an appointment or have a late cancellation.

Patient Signature _____ Date: _____

Patient Name (print) _____

Name of Custodial Parent/Legal Guardian _____

Parent/Guardian Signature _____ Date: _____