Main Street
CHIROPRACTIC

R. Brett Payne D.C.

Consent/Authorization

_____ I _____ authorize the performance of diagnostic x-rays, physical exam procedures and comprehensive chiropractic care of myself, which the above-named doctor or their associates may consider necessary or advisable in the course of my examination and treatment.

_____ I also consent to the performance of other diagnostic and therapeutic procedures in addition to or different from those stated above, whether or not arising from presently unforeseen conditions, that the above-named doctor, associate, or assistants may consider necessary or advisable in the course of my healthcare.

_____ The nature and purpose of the procedures, possible alternatives, the risks involved, possible consequences, and the possibility of complications have been explained to me by the above-named doctor, and/or associates and assistants.

_____ I acknowledge that no guarantee or assurance as to the results that may be obtained from the procedure has been given by the above-named doctor, his associates or assistants.

_____ I _____ certify that, to the best of my knowledge, I am not pregnant and the above-named doctor and/or associates have my permission to perform a diagnostic x-ray examination. I have been advised that x-rays can be hazardous to an unborn child.
Date of last menstrual period _____

_____ I _____ certify the performance of a diagnostic x-ray examination of my child or ward, in which the above-named doctor or their associates may consider necessary on advisable in the course of my examination and treatment.

_____ I _____ authorize the above-named doctor and/or his associates and assistants to administer chiropractic care as deemed necessary to my _____ (relationship to child), _____ (name of child).

Dated at _____ (city), _____ (state) This _____ day of _____, 20__

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this 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 office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit 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. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me, will be immediately due and payable.

Patient/Parent or Guardian's Signature _____

Witnessed by: _____ C.A. Date _____

910 North Main Street, Ste.1 Euless, TX. 76039 PHONE: 817-358-3552 FAX: 817-358-3556