PITTSBORO CHIROPRACTIC CENTER
CONSENT TO CHIROPRACTIC SERVICES

PAYMENT AND INSURANCE **Pt. Initial _____**
I understand and agree that the health and accident insurance policies are an arrangement between the insurance carrier and myself. This 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 this office will be credited to my account. 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.

CONSENT TO TREATMENT OF A MINOR CHILD (IF APPLICABLE) **Pt. Initial _____**
I authorize the licensed doctor and whomever he/she may designate as assistant to administer chiropractic care as deemed necessary to my (Relationship) _____ (Name) _____.

FEMALE PATIENTS **Pt. Initial _____**
This is to certify that to the best of my knowledge I am NOT pregnant and that Pittsboro Chiropractic has my permission to take X-Rays. Beginning date of your last menstrual period _____

PATIENT'S RIGHTS **Pt. Initial _____**
Pittsboro Chiropractic respects the unique differences of our patients, and will ensure that health care ethics are maintained for all patients. The following rights will be exercised on our patients' behalf.

1. The patient has the right to considerate and respectful care.
2. The patient has the right to and is encouraged to obtain from his doctor relevant, current, and understandable information concerning diagnosis, treatment, and prognosis.
3. The patient has the right to make decisions about the plan of care prior to and during the course of treatment and to refuse a recommended treatment or plan of care to the extent permitted by law, and to be informed of the consequences of this action.
4. The patient has the right to every consideration of privacy.
5. The patient has the right to expect that all communications and records pertaining to his/her care will be treated as confidential, except in cases when reporting is permitted or required by law.

CONSENT TO CHIROPRACTIC SERVICES **Pt. Initial _____**
I hereby request the consent to chiropractic manipulations and other procedures including various modes of physical therapy, diagnostic X-Ray and/or tests by Pittsboro Chiropractic and their staff who now or in the future treat me while employed by this office. I have had an opportunity to discuss with a doctor and/or other clinic personnel the nature and purpose of treatment indicated. I understand that results are not guaranteed and I am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including but not limited to fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and wish to rely on the doctor to exercise judgment during the course of any procedure which the doctor feels at the time is in my best interest. I have read, or have had read to me, the full above consent and have also had an opportunity to ask questions about its content and by signing below I agree to the above terms and procedures. I intend this consent to cover any treatment for my present condition and for any future conditions for which I seek treatment by this clinic and/or employed staff.

SIGNED _____ Date _____
WITNESS _____ Date _____