

CONSENT OF TREATMENT

I acknowledge I am not pregnant and/or do not plan to become pregnant within 30 days of signing this consent. I authorize Vitality Chiropractic permission to render any/all treatment necessary to care for my condition and release Vitality Chiropractic from any/all liability.

Patient Signature: _____ Staff Signature: _____

REFUSAL OF X-RAY

I acknowledge I am pregnant and/or do not authorize Vitality Chiropractic permission to x-ray. I understand that refusal to such service may prohibit Vitality Chiropractic's ability to properly care for my condition. I do authorize Vitality Chiropractic permission to render any/all other treatment necessary and release Vitality Chiropractic from any/all liability.

Patient Signature: _____ Staff Signature: _____

CONSENT OF TREATMENT OF MINOR/CHILD

I, the legal parent/guardian/custodian of _____, age _____,
PATIENT FULL NAME

authorize Vitality Chiropractic permission to render any/all treatment deemed advisable and/or required. It is the understanding, of the undersigned, that Vitality Chiropractic will have full authority, by me, to continue with any/all treatment necessary until said minor has attained legal age and release Vitality Chiropractic from any/all liability. I, legal parent/guardian/custodian acknowledge and accept full responsibility for any/all charges and payments due to Vitality Chiropractic.

Guardian (Print Name): _____ Relation: _____

Guardian Signature: _____ Date: _____

AUTHORIZATION

I authorize Vitality Chiropractic permission to release any/all information, diagnosis and/or records of treatment rendered to me, and/or my dependent(s), to documented third party payers and/or insurance companies. I instruct any/all third-party payers and/or insurance companies to pay Vitality Chiropractic directly unless Vitality Chiropractic has instructed otherwise. I acknowledge and assume financial responsibility for any/all remaining charges due to me, and/or my dependent(s), to Vitality Chiropractic should the third-party payers and/or insurance companies not cover and/or pay. I understand, should I not meet my payment responsibilities, I am financially responsible for any/all interest/filing/collections/court/attorney fees associated with my, and/or my dependent(s), account with Vitality Chiropractic.

Patient (Print Name): _____

Patient Signature: _____ Date: _____

Guardian (Print Name): _____ Relation: _____

Guardian Signature: _____ Date: _____

CANCELLATION POLICY

Our goal at Vitality Chiropractic is to provide quality healthcare to all our patients. We understand your time is valuable, as well as ours. Late arrivals, no shows and/or cancellations not only inconvenience our Doctors, but also the other patients. In the event you are unable to keep your appointment, we do require a 24 hour notice. Should you not comply to this policy, you will be charged a \$25 cancellation fee. This does not apply for emergencies.

Patient Signature: _____ Staff Signature: _____