AGREEMENT

To Office Policy and Rules

1.) I agree to the follow the doctor's treatment recommendations for me. I understand that I will be expected to make up any missed appointments. All missed appointments must be made up within seven (7) days.

2.) I agree to X-ray(s) and to follow all recommendations made by the doctor, including the proper use of my spinal supports, doing my exercises as prescribed, etc.

3.) I understand that any recommendation for future care will be made only after physical and/or X-ray reexamination.

4.) I agree to make a personal financial agreement and promptly fill out all necessary medical legal and insurance forms to aid in the timely payment for my care.

5.) I understand that if my insurance company has not paid my claim within ninety (90) days, a copy of that unpaid claim will be given to me and I will be responsible to follow up on the status of payment.

_____ _____

Signature of Responsible Party or Guardian Date

_____ _____

Witness Date

Patient's name if other than responsible party: _____

HEALTH THROUGH ADVANCED CHIROPRACTIC
ADDS YEARS TO YOUR LIFE AND LIFE TO YOUR YEARS