CHIROPRACTIC CENTER
149 Iron Point Road • Folsom, CA 95630
916-989-1014

Patient Name ______________________________

Patient# ____________ Date _______________

TERMS OF ACCEPTANCE

______ ______ CONSENT TO TREAT A MINOR:
(initial) (date)

I, _______________________, being the parent/guardian of __________________ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

______ ______ PREGNANCY RELEASE:
(initial) (date)

This is to certify that to the best of my knowledge, I am not pregnant and Dr. Finnell / Dr. Lyon have permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

______ ______ PRIVACY ACT NOTIFICATION:
(initial) (date)

I, the undersigned, have been made aware of and given a copy of the Notice of Privacy Practices at Core Chiropractic. I agree to read the notice and if I have any concerns or questions, I will ask the doctor or staff to clarify anything I don't understand.

______ ______ FINANCIAL POLICIES:
(initial) (date)

- All services are to be paid for before or at the time of service.
- All deductibles are to be paid for at the beginning of the course of care.
- All co-payments are due before or at the time of service.
- Prepayment plans are offered to all patients.
- Insurance verifications are done as a courtesy to all patients. We encourage our patients to also verify their insurance coverage.
- Any changes in coverage are the patients' responsibility to notify the staff.
- X-rays and exams are NOT covered by Medicare and therefore are the patient's responsibility and are to be paid at the time of service.
- When involved in a personal injury case, unless the patient is utilizing MED PAY on their insurance policy, an attorney must be acquired and a LIEN signed prior to the commencement of care. If no attorney is acquired, the patient must sign a "personal/medical" LIEN prior to care.

I have read and understand the office's Financial Policies set forth above and agree to be bound by these terms. I also understand and agree that such terms may be amended at any time by Core Chiropractic, without prior notification.

______________________________ ______________________________
Signature of Responsible Party Date

Printed Name ______________________________ Date ____________________

Signature ______________________________

Signature of Patient or Guardian ______________________________