



Patient and Doctor Agreement

I understand and agree that health and accident insurance are an arrangement between and insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare all necessary reports and forms to assist me in making collection from the insurance company, and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate care, any fees for professional services rendered to me on a pay-per visit basis will be immediately due and payable.

I hereby authorize the doctor to treat my condition as the Doctor deems appropriate through adjusting my spinal column, I understand and agree that the amount paid the Doctor for x-rays is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen by me at any time while I am a patient of this office. The x-ray negatives may be purchased from American Family Spine and Health, should I desire to do so. I also agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any preexisting medically diagnosed conditions, nor for any medical diagnosis.

Patient's Signature:

x _____ Date _____

Guardian of Spouse's Signature:

x _____ Date _____