Ackerman Chiropractic and Wellness

Registration Form

Date_____ Home Phone_____ Cell Phone_____

Email_____

Last Name_____ First Name_____Middle Initial___

Street Address_____

City_____State_____Zip_____

Sex:_____ Age:_____ Birth Date:_____ Occupation _____

Who referred you to this office? _____

PARENTAL CONSENT TO EVALUATE AND TREAT A MINOR

I _____, being the parent/legal guardian of_____

hereby grant permission for my child to receive chiropractic care.

CONSENT TO INITIATE CARE

Our goal is to render the highest quality Chiropractic care at the lowest possible fee. Please read over the procedures below to understand how our office functions, and to decide if you wish to participate. IF you have any questions, please let us know.

*We take no responsibility for non-payment by insurance companies for services rendered.

*Our office will not respond to any requests for paperwork for insurance purposes or even acknowledge insurance requests for information on any patient's case

* No balances can be kept or run by patients at any time.

* All adjustment visits are part of a wellness or package plan and payments are current or payments (initial visit or single visit) are made prior to or immediately after adjustment.

*No Refunds on unused packages plans or missed wellness plan visits.

*Our office reserves the right to deny services to anyone for any reason, or if the doctor feels that the patient's health is not being best served.

I wish to initiate care at this office. I have read and understand the Consent to Initiate Care and agree to all terms. I understand that I am under no obligation to receive or continue care.

Print your name:_____Today's Date:_____

Sign Your Name:_____