

INSURANCE POLICY – FRISCO CHIROPRACTIC CENTER

Frisco Chiropractic Center understands that you are seeking care at our office for health problems you feel require treatment.

We do our best to inform you of your contracted benefits, if applicable, and do our best to file and document your care as presented and preformed. We will also provide your insurance company with any requested additional information, in an attempt to secure reimbursement.

However, your insurance company has criteria included in your contract that may allow them to deny care. This generally relates to care your insurance company feels is unnecessary or is for maintenance only.

I understand that should my insurance company deny coverage for services rendered by the Frisco Chiropractic Center or deem them unnecessary; I will cover these unpaid charges.

PATIENT: _____

PATIENT OR LEGAL GUARDIAN SIGNATURE: _____ **DATE:** _____

CONSENT FOR CHIROPRACTIC TREATMENT – FRISCO CHIROPRACTIC CENTER

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, massage and diagnostic X-rays, on me (oron the patient named below, for whom I am legally responsible) by Dr. Flint Loughridge DC and/or other licensed doctors of chiropractic who now or in the future work at the clinic.

I have had an opportunity to discuss with the doctor of chiropractic and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

PATIENT: _____

PATIENT OR LEGAL GUARDIAN SIGNATURE: _____ **DATE:** _____