

# Baker Chiropractic & Acupuncture

## Policy Agreement

### Consent for treatment

I understand that my treatment/services(s) by Baker Chiropractic & Acupuncture is necessary because of my condition. I voluntarily authorize and consent to the usual examination and treatment(s) ordered by the doctor(s) and staff.

### Appointment Cancellations

It is our desire to provide you with the best possible attention and care. For this reason we do not double book your appointments. Baker Chiropractic requires 24-hour notice for cancellations. This will enable us to offer the time to other patients.

**Payment in full will be required if the patient does not provide timely cancellation notice.**

### Payment

Services, generally, are covered by majority insurance companies, therefore Baker Chiropractic & Acupuncture does not submit to any insurance. However, upon request, an itemized statement can be provided for personal submission.

**Payment is required at the time of visit. We accept the following forms of payment.**

Apple Pay / Android Pay VISA/ MC American Express Discover  
Health Savings Accounts, Cash and \*Personal Checks

*\* Patient account will be charged for any bank fee charged for If a personal check is dishonored checks.*

I have read, understand, agree and will comply with all the above policies of Baker Chiropractic & Acupuncture.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient signature

### Consent for treatment of a minor

I (we) being parent(s), guardian(s), custodian(s) of \_\_\_\_\_

A minor, the age of \_\_\_\_ with date of birth of \_\_\_\_\_, do hereby authorize, request and direct the Doctors of Baker Chiropractic and/or other providers to perform in her/his judgement and necessary exams, recommended treatments for minors condition.

\_\_\_\_\_  
Parent, guardians signature

\_\_\_\_\_  
Staff initials