

Back in Line Chiropractic Center

PATIENT DISCLOSURE AND ACKNOWLEDGEMENT FORM

Office Visit	Electrical Stimulation	Laser
Manual Therapy	Cervical Traction	Traction
Therapeutic Exercises	X-rays	Scan
Therapeutic Ultrasound	Gait Training	Other _____
Massage Therapy	Functional Activities	Other _____
Hot/Cold Pack	Balance Work	Other _____
Whirlpool	Ball Work	Other _____

1. I acknowledge that I received the treatment listed above.
2. I acknowledge that I have the right and affirmative duty to confirm that services listed was actually rendered
3. I was not solicited by this medical facility or any of its employees to seek medical treatment for injuries sustained as a result of this accident.
4. I understand that if the insured notifies the insurer in writing of any billing errors, the insured may be entitled to a certain percentage of the reduction in the amounts being paid by the insured's motor vehicle insurer.
5. The services being provided to me for which my doctor intends to bill my insurance been explained. I have had the opportunity to have any questions answered to my satisfaction.
6. I hereby acknowledge having been informed of the above and have consented to the treatment and billing for the treatment proposed by my provider.

Patient's Original Signature

Patient's Name (print)

Signature of Patient or Legal guardian

Date

Provider's Original Signature
(The treatment billed for has been explained to the patient)

Date