Dr. John C. Bauman D. C.
210 E. McLoughlin Blvd.
Vancouver, WA 98663
(360) 693-0400

Acknowledgment and Understanding

Please initial each item below.

1. _____ I hereby authorize Dr. John C. Bauman D.C. To provide chiropractic services to me.
2. _____ I understand and agree that regardless of insurance coverage, I am liable for any charges incurred as a result of services rendered to me by this chiropractic office.
3. _____ If this account is assigned to any attorney for collection and or suit, the prevailing party shall be entitled to reasonable attorney's fees and cost for collection.
4. _____ I hereby assign all chiropractic benefits, including major medical benefits in Medicare, private insurance and all other health plans for services rendered by Dr. John C. Bauman D.C.
5. _____ I authorize release of my records to third parties requiring them for determination of financial liability.

By signing this application, I affirm under penalty of law that I have given true, complete information.

_____

Patient's Signature Date

CONSENT TO TREAT

Chiropractic examination and therapeutic procedures (including spinal adjustment, heat/cold application and manual muscle therapy) are considered safe and effective methods of care. Occasionally, however complications may arise. Any procedure intended to help may have complications. While the chance of experiencing complications is small, it is the practice of this clinic to inform patients about them. These complications include, but are not limited to soreness, inflammation, soft tissue injury, dizziness, burns and temporary worsening of symptoms. More serious complications are extremely rare. Additional information on side effects and complications are available upon request.

I have read and understand the above statements regarding treatment side effects. I also understand that there is no guarantee or warranty of a specific cure or result.

_____

Patient's Signature Date