Patient Consent

Name: _____
Case #_____

Consent for Treatment

I, the undersigned, hereby authorize Dr. Keisha Pitt of Journey Family Chiropractic to perform diagnostic test, including but not limited to radiographs, and to administer treatment as necessary.

I, also, certify that no guarantee or assurance has been made to the results that may be obtained. I understand and agree that accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company that my account authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment.

Patient's Signature
_____Date_____Witness_____

Consent for Treatment of Minor

I hereby authorize Dr. Keisha Pitt of Journey Family Chiropractic to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as they deem necessary to my _____(indicate relationship of child) _____(child's name)
Patient's Signature _____Date
_____Witness_____