Treatment and Payment Agreement

I authorize examination and treatment for this and all following Chiropractic visits.

I authorize to release any medical information necessary to process insurance billings.

I authorize payment and assignment of insurance benefits to the doctor's office.

I am personally responsible for supplying accurate and current insurance information.

I understand I am financially responsible for all charges and deductibles not covered by my insurance
and/or if I supply false or incorrect billing information. I authorize a photocopy of this statement to serve as an original

Signature: _____ Date:_____

PATIENT ACKNOWLEDGEMENT OF

RECEIPT OF NOTICE

I hereby acknowledge receipt of the Notice of Privacy Practices for Jackson Chiropractic Clinic regarding my health information. I have been informed and understand the manner in which my health information shall be maintained, utilized and disclosed by Clinic and my respective rights there in. I also understand that the Notice furnished to me is subject to change at any time. I am aware that I may obtain a current copy of this Notice at any time by contacting 651-483-4321

Jackson Chiropractic Clinic
3508 Rice Street
Vadnais Heights, MN 55126

My signature herein below constitutes acknowledgment that I have been furnished a copy of the Notice of Privacy Practices for Jackson Chiropractic Clinic.

_____ _____

Patient Signature Date

_____ _____

Patient's Legal Representative
If required Date

If signed by patient's legal representative, please state representative's relationship to patient:

_____