ADAMS COUNTY CHIROPRACTIC

AUTHORIZATION FOR TREATMENT

l,, by signing this form, am
requesting and consenting to the diagnostic and therapeutic procedures which may include, but are not limited to chiropractic, massage therapy, exercise, nutrition counseling and education to be performed by Adams County Chiropractic clinicians and staff.
I hereby warrant that I have not been legally adjudged as incompetent. I understand that it is my right to determine the extent of my medical care and that I may, at any time, refuse treatment and withdraw my consent for the performance of any procedure or treatment.
I recognize that no guarantees have been or can be made regarding the likelihood of success or the outcome of any evaluation, treatment, test procedure, or therapy performed by Adams County Chiropractic physicians and/or staff.
I hereby warrant that I have read and understand to my satisfaction all of the above.
Authorization of Patient/Representative:
Patient Signature DATE:
Representative Signature
Representative Canacity

ADAMS COUNTY CHIROPRACTIC



Dr. Phillip B. Andrus, DC 775 Old Harrisburg Rd • Gettysburg, PA 17325 Phone (717) 337 - 1759



Dear Patient,

Please be informed that Dr. Phillip Andrus has agreed to participate with your insurance program in order to better serve his valued patients. As you know, this often means that he also agrees to discount his fees to your insurance company as a convenience to you.

Often times insurance companies will not cover necessary services. This means that there may be at times when additional office visits, massage therapy, adjunctive therapy procedures such as ultra-sound or electrical stim, and exercise rehabilitation services that are a necessary part of your care may be denied payment by your insurance company.

We want you to be aware that while we accept a discounted fee for a covered service, if you receive a service that your insurance refuses to cover, you will be responsible for that cost.

I have read the above and agree to be responsible for any non covered expenses.

Patient's Name printed	
Patient's Signature	
Date	