Patient Acceptance Form

I hereby authorize the physicians and/or assistants of Active Life Chiropractic and Wellness, LLC to examine me, including X-rays, if indicated by the exam. I authorize treatment in an open room where other patients are also being treated. I am aware that other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor or other staff member at any time in private, a room will be provided for these conversations. I further authorize treatments deemed necessary by the findings and I wish all my medical records to be kept in strict confidence and not to be given to anyone without my written consent. **By signing my name below, I certify the accuracy of my medical and/or accident history and further certify that I present to the physicians for evaluation and/or treatment of a health related condition and for no other purpose. I clearly understand that I am totally responsible for payment should my insurance company deny payment or make payment to me. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.**

All X-rays and office notes remain the property of this clinic.

Date: _____

Print Patient Name _____

Patient Signature _____

Parent/Guardian Signature _____

Witness _____

Active Life Chiropractic and Wellness, LLC
921 Longtown Rd, Suite F
Columbia, SC 29229
803.699.0266
dremilydrew@gmail.com