LAKEWAY SPINE CENTER

Authorization for Care of Minor

I / We, the undersigned parent(s) and/or guardian(s) of:

_____ SS#: _ _ _ - _ _ - _ _ _ _ ,

a minor, do hereby authorize this office and its doctors to administer chiropractic care and all appropriate therapies to my child, as they deem necessary.

Parent or Legal Guardian's Name (please print)	Date
Parent or Legal Guardian's Signature	Date
Witness Signature	Date

Agreement for Payment of Services

By signing the authorization above, I affirm that I understand and agree that:

- Health and accident insurance policies are an arrangement between patients and their insurance carriers.
- This office will prepare any necessary reports and forms required by insurance companies for payment of services.
- Any amount that is authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse insurance payments to be applied to my account.
- All services rendered to me are charged directly to me and I am personally responsible for the payment of my account.
- It is the policy of Lakeway Spine Center to collect for services as they are rendered, unless other financial arrangements are made.

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