

Virginia Family Chiropractic & P.T., PLLC

PATIENT CONSENT FORM

Date: _____

I, the below-named patient, do hereby authorize any payments for medical services rendered to me, be directed to Virginia Family Chiropractic and P.T., PLLC.

I authorize Virginia Family Chiropractic and P.T. ,PLLC to sign any and all settlements, bank drafts, money orders and cashier checks that are intended for payment for any and all medical treatment rendered.

Patient's name (please print)

S.S.N. #

Patient's Signature

Patient's D.O.B.

Witness (please print name and sign)

Note: *Parent or Guardian of patient under 18 years old of age must sign.*