Informed Consent: Patient consents to care and accepts responsibility. I consent to recommendations and care by Dr. Jennifer Fletcher for myself (or my child if a minor), including but not limited to examinations, x-rays, chiropractic adjustments, rehabilitative and physiotherapy. I understand that my care will be individualized to me and therefore may not be comparable with standards or guidelines used or required by insurance companies, professional associations and/or consensus groups. I understand that my treatment will comply with the standard of care defined by the laws in the State of Oregon. I understand that Chiropractic care, as with any health intervention, has inherent risks. These risks, though rare, could occur ranging from minor aggravation of current condition to serious conditions such as cerebral vascular accident or death. I am signing this consent after being fully informed by Dr. Jennifer Fletcher and/or her staff of the risks and benefits of the care and the risks and benefits of not having the recommended treatment. I have been informed and fully understand that there is no guarantee of treatment success by my presence and continuation of appointments. I consent and elect to care provided by Dr. Jennifer Fletcher and/or her staff.

If you are recommended nutritional supplements as part of our wellness program or as an adjunct to your chiropractic care as allowed by NRS 634.013: "Chiropractic is defined to be the science, art and practice of palpation and adjusting the articulations of the human body by hand, the use if physiotherapy, hygienic, nutrition and sanitary measures and all measures of diagnosis," this is to inform you that the purpose of the recommendation is to holistically provide the body with nutritional support so that the body may heal itself. The purpose of this statement is to clarify that under no circumstances should the patient be led to believe the doctor of Chiropractic or its' representative are practicing medicine by treating any disease. The doctor of Chiropractic or its' representative do not recommend any patient stop or start taking any prescription or medication.

Agreement to Financial Policy: I have agreed to pay any cash balance of said professional service charges at time of service. In addition, I agree to pay charges over, above or denied by insurance coverage's according to the financial policy of the doctor of Chiropractic. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

Assignment and Instructions for Direct Payment to Doctor: I hereby instruct the insurance company to pay by check made out and mailed directly to the above named doctors or, if my policy prohibits direct payment to Doctor, then I hereby instruct and direct you to make out the check to the undersigned (myself) and mail it to the above named doctor for the benefits available.

Diagnostic Films are Property of this Office: As allowed by NRS 629.961: "The provider of health care shall also furnish a copy of the records to each person described in subsection 1 who requests it and pays the actual cost of postage, if any, the costs of making the copy, not to exceed 60 cents per page for photocopies and a reasonable cost for copies of x-ray photographs and other health care records produced by similar processes." The fee paid for x-rays are for analysis only. The original film itself is property of this office and cannot be released. Copies of films are available for a charge of $6.00 per film paid in advance.

Patient will truthfully and fully disclose health status and history: I hereby state that all information I give to Dr. Jennifer Fletcher and/or her staff will be complete and truthful. I will not misrepresent to the presence, nature, severity or cause of my injuries. I further state that I will fully disclose my health history and authorize the release of all past medical records to Dr. Jennifer Fletcher. I present myself for health reasons only and it is not my intent to neither mislead, defraud or coerce this office or any third party nor misrepresent myself in any manner.

Copy as effective and irrevocable as original: A photocopy or NCR form or this Assignment Agreement, release, limited power and property or other office forms shall be considered as effective and valid as the original. The authority granted shall become effective upon signing and be irrevocable for the full extent of my treatment by the Doctor and until the time that all medical expenses incurred have been paid in full.

Medicare Patients: Medicare does not provide coverage for: examinations, radiographs (x-rays), physiotherapy modalities (ultrasound, muscle stimulation, diathermy) rehabilitation or nutritional items. The patient is responsible for additional fees resulting from those services. Medicare will not reimburse for services which are considered not medically necessary. Specifically, maintenance visits are not a covered benefit and visits in which your pain level is zero.

I have reviewed and understand and agree with the above policies, use and/or disclosure.

Print Name	Patient Signature
Signature of Legal Representative	Relationship Date