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**Family Chiropractic of Lederach, LLC**

658 Harleysville Pike, Suite 110

Harleysville, PA 19438

215-256-8006

Lederachchiro.com

Welcome!

We are honored to have you as a member of our practice and appreciate you taking the time to carefully review our practice policies.  Please ask anyone on staff if you have questions regarding these policies.

After reading through the policies, please complete and sign this form then present it to the front desk with your driver’s license and insurance card.

(initial) \_\_\_\_\_ I have read, understand, and agree to the **Patient Policies**

(initial) \_\_\_\_\_ I have read, understand, and agree to the **Chiropractic Maintenance Policy**

(initial) \_\_\_\_\_ I have read, understand, and agree to the **Informed Consent to Care**

(initial) \_\_\_\_\_ I have read, understand, and agree to the **Assignment, Release, Fee Schedule**

(initial) \_\_\_\_\_ I have read, understand, and agree to the **HIPAA Policy**

Copies of these policies are available at the front desk.

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth:\_\_\_\_\_\_\_\_\_\_\_

Signature   X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Responsible Adult of Minor Patient:

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



