FIRESTONE
CHIROPRACTIC & WELLNESS

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Consent and Policies Agreement

Please read the statements below and initial them to confirm that you have read and understood them. If you have any questions, please ask.

________ I grant permission to Firestone Chiropractic & Wellness to perform diagnostic testing and rendering of Chiropractic, Nutrition Counseling, and Massage Therapy services.

________ I authorize Firestone Chiropractic & Wellness to collect my personal and medical information as documented above. This information is confidential and will not be disclosed to 3rd parties without my consent. I give permission for Firestone Chiropractic & Wellness to contact me and leave a message at any of the above telephone numbers.

________ Firestone Chiropractic & Wellness maintains a professional environment and therefore reserves the right to cancel or terminate any session in the event the client's behavior is considered inappropriate. This includes, but is not limited to, intoxication, being under the influence of drugs, or sexual advances. Misbehavior of any sexual nature will result in immediate termination of the session and will be reported to the authorities. Payment for the service will be rendered in full. Termination of the session is at the discretion of the Doctor or therapist and does not require an explanation.

________ I understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment of which I am aware. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly.

________ Appointment Cancellation Policy: Please provide us 24 hour advance notice when cancelling an appointment, except in the case of emergency or sudden illness. Cancellations or missed appointments without 24-hour notice will result in a full charge for the appointment or session.

I have read the above statements and understand the policies of Firestone Chiropractic & Wellness.

Patient/Guardian Signature________________________________ Date: ________/________/__________

Minor Name ________________________________ Minor DOB: ________/________/__________