Authorization to Treat and Promise of Payment

I understand and agree that health and accident insurance policies are an arrangement between an insurance company and me. Furthermore, I understand that *Thacker Chiropractic Clinic, LLC* will prepare necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to *Thacker Chiropractic Clinic, LLC* will be credited to my account on receipt. I understand and agree, however, that all services rendered to me are charged directly to me, and that I am personally responsible for payment, including any collection agency fees, court cost, and any interest applied to outstanding balances. A photocopy of this authorization will be as valid as the original.

I hereby authorize any provider at *Thacker Chiropractic Clinic, LLC* to treat my condition as he deems appropriate through the use of procedures authorized by the state of Georgia for the Chiropractic profession. I further agree that the doctors at *Thacker Chiropractic Clinic, LLC* will not be held responsible for non-disclosed and pre-existing medical conditions.

Signature_____Date_____

Guardian or Spouse Authorizing Care_____Date_____