Bay Oaks Chiropractic
Dr. Joel D. Duchon
17080 Highway 3
Webster, Texas 77598

AUTHORIZATION TO LEAVE MESSAGES AND SEND INFORMATION VIA USPS

I authorize Dr. Joel D. Duchon and/or her employees to mail information regarding my account and/or care to my home. I also authorize the same to leave necessary telephone messages and/or make necessary telephone calls relating to the same. I would prefer to be contacted at:

_____ HOME

_____ OFFICE

_____ CELL PHONE NUMBER: _____

GENERAL CONSENT FOR TREATMENT

I, knowing that I am suffering from a condition requiring diagnostic, chiropractic, physiotherapeutic, radiographic, and/or rehabilitative procedures and/or treatment, do voluntarily consent to such procedures and care and to such services under the general and specific instructions of DR. JOEL D. DUCHON or designee(s) as is necessary. I also acknowledge that I understand that the practice of chiropractic – as is true with all medically -related arts- is not exact science and no guarantees have been made or will be made as to the results of such treatments and/or procedures.

I understand that I am to give 24 hours notice to cancel appointments and failure to do so will result in a $25 fee. The same fee applies to missed appointments.

DATED THIS _____ DAY OF _____, 20____.

SIGNATURE OF PATIENT:_____
(or parent/guardian if a minor)

PRINTED NAME:_____

_____***DO NOT WRITE BELOW THIS LINE***_____

WITNESS:_____