SIGNATURE FORM

Asula Wellness Center

THIS FORM MUST BE SIGNED BEFORE ANY TREATMENT IS PERFORMED.

Please Initial Below

_____ **Asula Policies**

I have read and understood Asula Chiropractic & Wellness Center's policies regarding:

- *24 Hour Cancellation Notice*
- *Sexual Harassment*
- *Financial Policy*

_____ **Payment Preferences for Outstanding Balances**

For your convenience, we prefer to save a credit card to your file. Deductible, coinsurance, copay and self-pay amounts will be charged according to the payment option selected below. Any outstanding balance total that is higher than the payment option selected will be confirmed with you before it is charged.

Please select the option that is most comfortable for you.

□ Charge my card on file for balances $40 or less
□ Charge my card on file for balances $150 or less
□ Charge my card on file for balances _____ or less

*If none of the above options are suitable to your needs, then please check in with the front desk to discuss possible alternatives.

_____ **Informed Consent to Treat**

I understand the risks below with undergoing treatment. If requested I have received the additional explanation and clarification of risks.

_____ **HIPAA Notice Of Privacy Practices, Asula Chiropractic & Wellness Center**

I understand that I may ask questions to the Medical Practice if I do not understand information contained in the Notice of Privacy Practices.

_____ **Consent For Purposes Of Payment And HealthCare Operations**

I understand that I am financially responsible for all charges on my account.

Signature _____ **Signature of Parent or Guardian** _____

Date _____ **Date** _____

OFFICE USE ONLY

□ **ADDENDUM A** □ **ADDENDUM B** □ **Email Receipt**

□ CC info has been stored on file or verified

Initials & Date: _____

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