

Austin Hills
CHIROPRACTIC

3839 Bee Caves Road
Suite 206
Austin, Texas 78746
512-585-4654

Date: _____

I _____ (the patient) have been informed that Dr. Rachel Bailey DC does not participate in any insurance program including Medicare and does not have an updated provider number. I understand that the doctor does not have staff to fill out medical forms. I waive my right to ask the doctor to fill out any insurance or Medicare paperwork and agree to pay for services when rendered. I understand that the practitioner will help me with a referral if I choose to enter the Medicare system.

Patient Signature

Date of Birth

Witness