



Ash Chiropractic & Acupuncture Clinic

Ashraf A. Soomar-Kheraj, B.S., D.C.

ACUPUNCTURE CONSENT FORM

I, _____, hereby seek health care at **Ash Chiropractic & Acupuncture** from
Patient's Name

Ashraf Soomar-Kheraj, D.C., FASA and I acknowledge the following:

1. It has been explained to me that chiropractic is not a cure-all, and acupuncture is not a cure-all, and of all the cases accepted, an average of 8 out of 10 respond favorably.
2. I agree that if I have any complaints, I will first consult with the doctor to seek adjustment and resolve the matter in question.
3. I realize that acupuncture treatments may be performed with a non-piercing needle, electro-stimulation, piercing needles, or the method(s) the doctor determines would be most beneficial to my case.
4. I have come to **Ash Chiropractic & Acupuncture** of my own volition.
5. I realize that any insurance I have may cover all, part, or none of my health service fees.
6. I understand the following policy of **Ash Chiropractic & Acupuncture**:
 - a. Any patient with insurance coverage is responsible for any amount their insurance company does not cover. We are happy to fill out all insurance forms and submit to your insurance company.
 - b. Any patient without insurance coverage is responsible for 100% of services rendered. All services are due upon receipt unless otherwise determined with/by the doctor's staff.

The doctor has recommended that I undergo regular, routine medical checkups by my medical doctor, and/or continue any care I may be receiving from my primary care physician and/or specialist concurrently.

Patient Signature:

Patient's Name (Print):

Date:

PIN #:

Witness' Signature:

Witness' Name (Print):

Date:

Dr. Initials:

Parent/Guardian's Signature:

Parent/Guardian's Name (Print):

Date:

Dr. Initials:

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