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Angela Baylis, DC, DCBCN

Levridge Wellness Center
218 Snow Avenue
Raleigh, NC 27603

Patient Name*

DOB*

Consent to Treat a Minor

I hearby stipulate that I am the legal guardian of the child and grant my consent for the treatment of the child as provided for herein. The patient may refuse treatment at any time.

Parent/Guardian Full Name

READ AND SIGN EACH SECTION INDICATED

Consent to Professional Treatment

The patient certifies that all information provided to this office is true and correct, to the best of their knowledge. The patient grants their consent to this office and its staff to render treatment as deemed necessary by the attending physician. The patient may refuse treatment at any time.

Patient (Guardian) Signature*

Consent to Diagnostic Imaging

The patient consents to the performance of diagnostic imaging as deemed necessary by the attending physician of this office.

Patient (Guardian) Signature*

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Consent to Diagnostic Labs

The patient consents to completing all diagnostic lab work prescribed by Dr. Angela Baylis.

Patient (Guardian) Signature*

INSURANCE POLICY

1. Our office DOES NOT participate in any insurance programs.
2. Our services ARE NOT covered by insurance.
3. Your office visits are based on TIME, not by procedure.

THEREFORE, YOUR VISITS CANNOT BE TURNED IN TO YOUR INSURANCE COMPANY FOR REIMBURSEMENT. AS A PATIENT OF THIS OFFICE, YOU AGREE TO THE TERMS OF THIS POLICY.

Patient (Guardian) Signature*

Financial Obligation & Appointment Policy

The patient accepts full financial responsibility for services rendered by this practice. This office reserves the right to charge fair market value to your card on file for missed appointments or appointments cancelled without 24-hours advanced notification required by this office.

Patient (Guardian) Signature*

DATE*