

Atlas Chiropractic

2811 McKinney Avenue
Suite 240
Dallas, TX 75204
V: 214)999-1019
F: 214)999-1051

Termination of Care Waiver

The undersigned patient and/or responsible party, in addition to continuing personal responsibility and in consideration of treatment or services rendered or to be rendered assigns to the physician or facility named above the following rights, powers and authority:

TERMINATION OF CARE WAIVER: I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my caring doctor at this chiropractic clinic, he/she has full and complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time.

A photocopy of this instrument shall serve as original.

Signature of Patient or responsible party _____ Date _____