

OFFICE POLICY

Welcome to our office. Our goal is to serve you with exceptionally friendly and prompt service, and to provide the best in chiropractic care and massage therapy for your whole family.

APPOINTMENT SCHEDULING/MISSED APPOINTMENTS

In order to provide proper chiropractic care, a personal treatment plan will be designed specifically for you. If an appointment must be changed, 24 hours notice is appreciated.

LATE or MISSED MASSAGE APPOINTMENTS

- There will be no charge for massage appointments canceled 24 hours or more prior to appointment time.
- No shows and cancellations made without a 24 hour notice of the appointment time will result in a charge of \$35 whether a 90, 60, or 30 minute massage was scheduled.
- If a patient with insurance is 15-30 minutes late for their hour massage, the insurance can be billed for a half hour appointment and the patient will be charged for a half hour massage.
- If a patient without massage coverage is late for their appointment, it will take time from their massage and the full fee will be charged.
- When a patient is 30 minutes late without notification, the therapist is free to see another massage patient for the remainder of that hour.
- A missed appointment fee cannot be billed to your insurance.
- **Please Note: The 90, 60, or 30 minute massage appointment time will include patient and room prep.**

Initial _____

CHILDREN/FAMILY

Once you understand that the nervous system controls and coordinates all functions of the body and subluxations interfere with nerve flow, we expect that you would want everyone in your family to be under Chiropractic Care. We extend an opportunity to have your immediate family members seen for a no charge consultation and exam within the first thirty days of your starting date. This represents a \$65-\$85 value for each family member.

Initial _____

FINANCIAL AGREEMENTS

Payment is expected as services are rendered unless prior financial arrangements have been made. The fee for a returned check is \$25.00. If for any reason you cannot keep your financial agreement, please speak to the office manager immediately to eliminate any misunderstandings.

Initial _____

REMEMBER

Spinal correction and healing take time. If you do not feel satisfied with your body's responses, please make an appointment to discuss this with the doctor. We want you to get the most from your chiropractic care.

Initial _____

TREATMENT OF A MINOR

I, _____ being the parent/legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

PREGNANCY RELEASE

This is to certify that to the best of my knowledge, I am not pregnant, and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that an x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: ____/____/____

Initial _____

Signed _____ Date _____

Parent Signature _____

Witness _____