

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 for your whole family. It is our experience that our patients who follow these simple guidelines obtain the best results and greatest benefits to their health.

APPOINTMENT SCHEDULING/MISSED APPOINTMENTS

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

Massage appointments that are missed or not canceled at least 24 hours before the scheduled appointment time will be charged for the appointment. If you are late for your appointment it will take time from your massage and the full fee will be charged. Please note that the missed appointment fee will be charged directly to the patient's account and not billed to the insurance company. For a more detailed policy regarding missed massage appointments, please refer to the massage therapy office policy.

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 checked. We extend an opportunity to have your family checked for a special discounted price of only \$37 during the first thirty days of your starting date.

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 _____