

PATIENT ACKNOWLEDGEMENT FORM

Please initial next to the following paragraphs to show that you acknowledge and agree with the policies described below

1. _____ **Cancellation policy:** We require a courteous minimum of 12 hours prior to the cancellation of a treatment session (massage or chiropractic) OR before the office opens at 8:30 AM. Those who give less than 12 hours' notice or fail to cancel before opening will be subject to a cancellation fee of \$45 for a chiropractic session or \$50 for a massage therapy session. Emergency cancellations are determined at the doctor's discretion (work is not automatically considered an emergency). We enforce this policy due to the fact that your appointment takes up a 15 minute slot that someone else was trying to schedule in, which in the end robs someone the opportunity to be helped/healed and it also wastes the time of the staff and doctor.

2. _____ **Session start and stop time policy:** I understand that the scheduled treatment session will begin and end on the time previously scheduled before the visit. If I show up late or past my scheduled treatment time I acknowledge and accept the fact that I may not receive my full duration of treatment time or services scheduled.

3. _____ **Extra services policy:** I have chosen to receive supplies and / or services that are not part of the standard of care for chiropractic care and I have been fully informed, before services were rendered, that I am fully responsible for: Massage therapy / myofascial therapy / manual therapies / exercise rehabilitation / instrument assisted soft tissue manipulation / kinesiology taping / trigger point therapy / red light therapy, and / or supplies and / or orthotics because my insurance will not cover these services or there is a co-pay, co-insurance or a write off of all or part of the supplies / services provided. I agree to pay in full for the supplies and / or services rendered.

Print Name

Signature

Date