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). Those who give less than 12 hours' notice will be subject to a cancellation fee of $25 for a chiropractic session or $50 for a massage therapy session. Emergency cancellations are determined at the doctor's discretion (work is not considered an emergency).

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**