

## AGREEMENT

### To Office Policy and Procedures

1. I agree to the following appointment schedule. I understand that if I must cancel, I agree to do so 4 hours prior to my scheduled appointment time. I will be expected to make up any missed appointments. All missed appointments must be made up within seven (7) days (barring any emergencies, vacations or trips out of town.) Failure to make up any missed appointment will result in a service charge of \$ 25.00 and will be billed to me directly and is not payable by insurance, lien, workers compensation, etc.
2. I agree to follow all other recommendations made by the doctor(s), including the proper use of my spinal supports, doing my excercises as prescribed, etc.
3. I understand that any recommendation for future care will be made only after physical and/or x-ray examination.
4. I understand when arriving for each office visit, I will sign in at the front desk. If I am late, I understand that I may have to wait for the next available appointment or reschedule for another time.
5. There will be a \$35.00 charge (additional to bank charge) for returned checks (insufficient funds). If your account is sent to a collection agency, a 35 to 50% collection fee will be added.
6. We submit Chiropractic services to your insurance if benefits are available.  
**However, acupuncture and massage are non-billable services in our office.**
7. Multiple appointments should be scheduled in advance for your convenience. It is the frequency of visits that provide the greatest benefits.
8. Please do not leave valuables in any room, on the coat rack, or in the waiting room. We cannot be responsible for them.
9. I agree that I have read the Office Policy and Procedures and understand it.

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Signature of Responsible Party, Parent or Guardian

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Date

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Print Patient's Name