FAMILY WELLNESS
CHIROPRACTIC

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OFFICE POLICY

Our goal here in this office is to assist you in REGAINING and MAINTAINING your HEALTH so that you can live your life to your maximum potential.

When entering the office on any given visit, please go directly to the front desk and check in.

The closer you keep your appointments in the beginning, the faster you will see results. Each visit builds upon the last. Skipping appointments will only set back your progress. Please be aware that it is the **FREQUENCY** of the visits that counts and what allows your body to heal in the most efficient manner possible. This is what the doctor just reviewed for you in your report of findings; therefore, if you are unable to keep an appointment for any reason, we ask that you call as soon as possible to **RESCHEDULE** your visit. The front desk is here to help you incorporate these visits into your daily routine with ease. We are open until 6:00 pm on Monday - Thursday and open early at 6:30 am on Fridays to help accommodate most patients' schedules.

The doctor has recommended that you receive a certain amount of adjustments according to the treatment plan that suits you best. We ask that you schedule multiple appointments in advance in order to minimize wait time and to easily incorporate these appointments into your daily routine.

Walk-ins are welcome but there is no guarantee of service. Regular pre-scheduled appointments take priority.

We attempt to honor all appointment at their scheduled time. If you are late, you may have to wait for the next available appointment. We will do our best to efficiently fit you into the schedule for that day.

We ask for a 24-hour notice when cancelling or changing appointments. We reserve the right to charge a **no-show fee** for those who have not given a 24-hour notice.

FINANCIAL POLICY

____I would like to pay for **EACH VISIT** at the regular price of $_____

____ I would like to **invest in my health** and commit to a yearly care plan paying **MONTHLY** payments

____ I would like to **invest in my health** and commit to a yearly care plan paying **ONE-TIME** up-front

____ I would like my **whole family** to benefit from a yearly care plan paying yearly or monthly.

I have read and fully understand the office policy reviewed with me today.

Print Name: _____ Date: _____

Patient's Signature: _____

Witness:_____