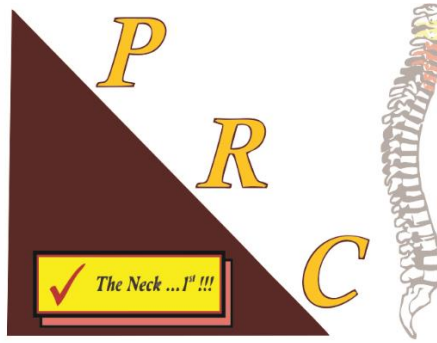


Paul D Pierce, DC

Blair Upper Cervical
Specific Chiropractor



Celia F Ringstad, DC

NeuroMuscular
Re-Education Specialist

Superior Health Solutions

General Policy

Welcome to PRC-Pierce Ringstad Chiropractic. We look forward to working with you on your Chiropractic needs. This document contains important policy information that pertains specifically to you. Please read over the entire document, initial where indicated, and sign the bottom. If you have any questions please feel free to ask one of the doctors.

Appointments

Initial

We consider an appointment to be an agreement between you and our office. This is a busy practice and the doctors take pride in helping each and every person. If for any reason you need to and do not cancel your appointment your chiropractor becomes unable to provide service to another patient during your scheduled time. We are responsible to be onsite and provide our services, or inform you, otherwise you are responsible for keeping your appointment or **give us a 24 – business hour cancellation. If no cancellation, you will be charged for the missed appointment.**

Payment

Initial

PRC requires payment in full at the time services are rendered. For your convenience we accept Cash, Check, Visa, MasterCard, American Express. There will be a \$40.00 fee for all returned checks.

Insurance

Initial

PRC is not a recognized provider for any insurance companies nor does PRC submit claims to insurance companies on your behalf. We will however, provide you with the information necessary for you to submit your claim to your insurance company. This does not insure any coverage from your insurance company or reimbursement.

Emergencies

Initial

If you have a true medical emergency or serious medical concern you are to call 911 immediately. If you have an urgent problem please call the office. If it is after regular business hours (10am-6pm, MWF) please leave a message and someone will call you back the following day. If you feel you cannot wait until the following business day, it is your responsibility to seek appropriate medical care.

I am a consenting adult of at least 18 years of age or older. I have read this document completely and I understand and agree with all of its contents demonstrated by my signature below.

Patient Signature: _____

Date: _____