Patient Intake
AUTO

SOS CHIROPRACTIC
8991 Daniels Center Dr. #105
Ft. Myers, FL 33912

Patient Title: *(check one)*	❑ Mr.	❑ Mrs.	❑ Ms.	❑ Miss	❑ Dr.	❑ Prof.	❑ Rev.
Name:				Nickname:		
Address:						
City:		State:			Zip:	
SSN:		Age:		DOB:		Sex:
Marital Status: ❑ *Single*	❑ *Married*	❑ *Divorced*	❑ *Widow*	❑ *Other*	Name of Spouse:	
Phone #: (*H*)		(*Cell*)			(*W*)	

Auto Insurance Company-	Adjuster's Name:
Policy #	Claim #
Insured's Name-	Relation to Insured-
Date of Accident / /	
By signing below I understand and agree, it is my sole responsibility as patient to notify the physician's office of any and all changes in my health insurance plan/policy. I understand failure to do so in a timely manner may result in the charges being my sole responsibility. I also authorize release of any and all personal health information necessary to process any claim(s) to this office. I have read and understand all the above.	
Signature-	Date / /
We will need a copy of your auto insurance card	

Auto Insurance Information:

Law Firm Name-
Contact Name-
Phone Number ( ) -
Address-

Attorney Information: □ **Check here if you do NOT have an attorney at this time.**

Auto Accident History: Were you **AT-FAULT?** □Yes □NO

1. What type of vehicle were you in during your accident? □ Car □ SUV □Truck

Year: Make: Model: □4-door □ 2-door □Other_____

2. Brief description of the other vehicle(s) involved in the accident: □ Car □ SUV □Truck

Year: Make: Model: □4-door □ 2-door □Other_____

3a. What position were you in the vehicle? □ Driver □ Passenger-front □Passenger-rear(driver side)

□ Passenger-rear(middle) □ Passenger-rear(passenger side)

3b. Seat Belted?

□Shoulder/lap □ Lap only □None □ Other:_____

3c. Air bag deploy? □ Did □Did Not

4. The vehicle you were in was □stopped □traveling _____mph.

The other vehicle was □stopped □traveling _____mph.

The accident occurred on _____ (street name) and _____

(street name)_____ (city) _____ (state).

5. Point of impact on the vehicle you were traveling in: □Front Bumper □ Rear Bumper

Driver Side: □Front quarter panel □Driver door □ Passenger door □ Rear door

□ Rear quarter panel □Other:_____

Passenger Side: □Front quarter panel □Driver door □ Passenger door □Rear door

□Rear quarter panel □Other:_____

5a. Where were you looking?: □ ahead, cannot be certain □ ahead □ Down □ left □right

5b. Did any part of your body come into contact with the interior of your car? □Yes □ No

If yes, please describe where and what body part?_____

5c. Did you receive a head injury? □Yes □ No

5d. Did you lose consciousness? □Yes □ No

6. Any additional accident details:

Were police at the scene?□YES □NO Was an accident report written? □YES □NO □ May or may not have been

Were EMS at the scene?□YES □NO

Estimated damage to your vehicle? $_____ Was your Vehicle towed from the scene: □YES □NO

Estimated damage to the **other** vehicle? $_____

If you were NOT treated at the scene of the accident OR at any other health care facility, please SKIP to question 13.

Treatment History:

7. Were you treated at the scene □Yes □ No
If yes, by whom? (EMS, Police department, Fire department, etc…)_____

What injury were you treated for? _____

8. Did you travel via EMS to receive medical treatment? □Yes □No
If No, how did you travel to seek treatment? _____
Which hospital or care center did you arrive at? _____
Were you kept for an overnight stay at the facility? □Yes □ No

9. Did you receive any of the following imaging studies at the hospital:
□ X-rays □Ct-Scan □MRI
What part(s) of the body was the imaging done: _____

10. Please list ANY and ALL injuries that you sustained and treatment/tests that were done at the hospital

11. Did you seek treatment for any injuries from this accident from any other healthcare provider(s)?
□Yes □No
If so who? And what for? _____

12. What prescription medication did you receive for injuries from your accident?

Medical History:

13. Have you ever been involved in any previous accidents or other injuries?(Please list **all** and **when**)

14. Have you ever been treated for any previous neck or back injuries? □Yes □No
If so, what? _____

Name of previous treating physician(s) _____

15. Please list any health conditions you have:

16. Please list any previous surgeries you have had:

17. Please list any previous hospitalizations:

18. Please list any significant family health history:

Social History:

Number of children living with you? _____
Alcohol use: □None □ Occasionally □Socially □Daily How much? _____
Tobacco use: _____ packs per day for _____ years. When did you quit?_____
Recreational Drug use: _____

Occupational History:

What is your occupation? _____

What type of job duties do you do? _____

Have you lost any time off from work due to the accident? □Yes □No
If yes how much? _____ hours or _____ days.

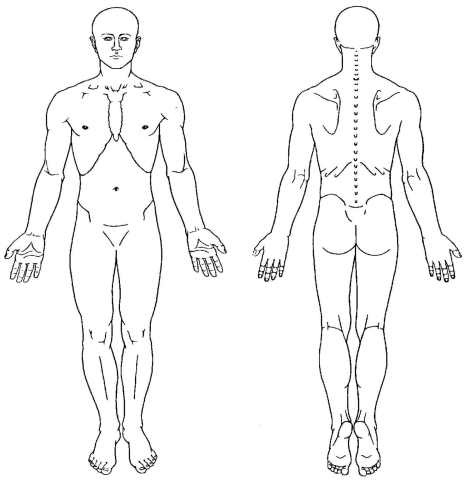
Have you returned to work □Yes □No Full duty or restricted? _____

Present Complaint:

Are you experiencing headaches? □ Yes □No How often? _____
Any additional comments you would like to make? _____

_____

Please mark the location of your pain:



Please check any or all symptoms you have:

___Neck pain
___Back pain
___Tension
___Balance changes
___Chest pain
___Numbness of finger
___Numbness of toes
___Fever
___Fatigue
___Light bothers eyes
___Ringing of ears
___Head seems heavy
___Diarrhea
___Loss of smell
___ Sleep problems
___Nervousness
___Feet cold
___Irritability
___Pins & Needles in arms
___Pins & Needles in legs
___Hands cold
___Shortness of breath
___Depression
___Loss of memory
___Upset stomach
___Face flushed
___Fainting
___Loss of taste

By signing below, I attest that the information given above is true to the best of my knowledge.

_____ _____
Signature Date

Current Complaints

CHECK ONLY THOSE THAT APPLY:

NECK:

Severity of pain: ❑ (none) ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10(worst pain)
The pain is: ❑ Constant ❑ Intermittent ❑ Seldom
The quality is: ❑Dull ❑aching ❑sharp ❑shooting ❑burning
❑throbbing ❑deep ❑nagging ❑other:_____
The pain is: ❑ On the left side ❑ On the right side ❑Equal on both sides

MID BACK:

Severity of pain: ❑ (none) ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10(worst pain)
The pain is: ❑ Constant ❑ Intermittent ❑ Seldom
The quality is: ❑Dull ❑aching ❑sharp ❑shooting ❑burning
❑throbbing ❑deep ❑nagging ❑other:_____
The pain is: ❑ On the left side ❑ On the right side ❑Equal on both sides

LOW BACK:

Severity of pain: ❑ (none) ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10(worst pain)
The pain is: ❑ Constant ❑ Intermittent ❑ Seldom
The quality is: ❑Dull ❑aching ❑sharp ❑shooting ❑burning
❑throbbing ❑deep ❑nagging ❑other:_____
The pain is: ❑ On the left side ❑ On the right side ❑Equal on both sides

HEADACHES:

Severity of pain: ❑ (none) ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10(worst pain)
The pain is: ❑ Constant ❑ Intermittent ❑ Seldom
The quality is: ❑Dull ❑aching ❑sharp ❑shooting ❑burning
❑throbbing ❑deep ❑nagging ❑other:_____
The pain is: ❑ On the left side ❑ On the right side ❑Equal on both sides

OTHER AREA: Please tell where the pain is: _____

Severity of pain: ❑ (none) ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10(worst pain)
The pain is: ❑ Constant ❑ Intermittent ❑ Seldom
The quality is: ❑Dull ❑aching ❑sharp ❑shooting ❑burning
❑throbbing ❑deep ❑nagging ❑other:_____
The pain is: ❑ On the left side ❑ On the right side ❑Equal on both sides

WHAT CAUSES YOU DIFFICULTY: (Check as many that apply)
❑Coughing / Sneezing ❑ Standing ❑ Lying down ❑ Walking
❑ Twisting or Turning ❑ Lifting ❑Bending ❑ Sitting
❑Rising to walk ❑Driving ❑Looking up ❑Looking down

PAIN IS WORSE: ❑ in the morning ❑ in the afternoon ❑ in the evening
Following: ❑routine activity ❑ moderate activity
PAIN INTERFERES WITH: ❑ work ❑sleep ❑ personal activities
❑other_____

Standard Disclosure and Acknowledgement Form

Personal Injury Protection – Initial Treatment or Service Provided

The undersigned insured person or guardian of such person affirms:

1. The services or treatment set forth below were actually rendered. This means that those services have already been provided.
   _____See Attatched_____
2. I have the right and the duty to confirm that the services have already been provided.
3. I was not solicited by any person to seek any services from the medical provider of the services described above.
4. The medical provider has explained the services to me for which payment is being claimed.
5. If I notify the insurer in writing of a billing error I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction up to $500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

_____ _____ _____

Name (PRINT or TYPE) Signature Date

The undersigned licensed medical professional or medical director, if applicable affirms the statement numbered 1 above and also:

A. I have not solicited or caused the insured person, who was involved in a motor vehicle accident to be solicited to make a claim for Personal Injury Protection benefits.
B. The treatment or services rendered were explained to the insured person, or his or her guardian, sufficiently for that person to sign this form with informed consent.
C. The accompanying statement or bill is properly completed in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to truthfully, accurately and in a substantially complete manner.
D. The coding of procedures on the accompanying statement or bill is proper. This means that no service has been upcoded, unbundled or constitutes an invalid or not medically necessary diagnostic test as defined by Section 627.732 (15) and (16), Florida Statutes or Section 627.736(5) (b) 6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable (*Signature by his/her own hand):*

_____ _____ _____

Name (PRINT or TYPE) Signature Date

Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234 (1) (b), Florida Statutes.

Note: The original of this form must be furnished to the insurer pursuant to Section 627.736(4) (b), Florida Statues and may not be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

SOS CHIROPRACTIC
Authorization to Pay Physician

I hereby authorize _____Insurance Company to make check payable and mailed directly to:

SOS CHIROPRACTIC
8991 Daniels Center Dr. #105
Ft. Myers, FL 33912

The medical expense and benefits allowable and otherwise payable to me under my current insurance policy, as payment toward total charges for professional services rendered. I designate SOS Chiropractic as third party beneficiary to the PIP coverage, med pay or any other first party benefits that I may be entitled to under the insurance policy with the above named insurance company. This payment will not exceed my indebtedness to the above mentioned assignee, and I agree to pay, in a current manner, all outstanding charges related to services rendered by SOS Chiropractic. In the event of non-payment, I agree to be responsible for all costs of collection including attorney's fee in the amount of 20% of the balance due to SOS Chiropractic

If my current policy prohibits direct payment to my doctor, then I hereby authorize you to make a check payable to me and mail as the following:

_____
(Patient's Name)
SOS CHIROPRACTIC
8991 Daniels Center Dr. #105
Ft. Myers, FL 33912

This is a direct assignment of my rights and benefits under the policy # _____.

A photocopy of this statement shall be considered as effective and valid as the original. I also authorize release of any information pertinent to my case to any other insurance company, adjuster or attorney in this case.

_____ _____
(Signature of Policyholder) (Date)

_____ _____
(Claimant Signature) (Date)

_____ _____
(Witness Signature) (Date)

SOS CHIROPRACTIC

8991 Daniels Center Dr. #105, Ft. Myers, FL 33912

Date: _____

Patient: _____

DOA: _____

Claim: _____

Enclosed is the initial billing information for our patient. If you have any questions please feel free to call the office.

Thank you,

Medical Billing

Tax ID: 46-5431196
License Number: CH 10931 (Dr. Ashton Begg)
NPI: 15183710004 SOS Chiropractic

1417379116 Dr. Ashton Begg

SOS CHIROPRACTIC
8991 Daniels Center Dr. #105
Ft. Myers, FL 33912
(239) 677-3593 Fax:(239) 677-3576

ASSIGNMENT OF BENEFITS: regrading_____, a person being at least eighteen years of age and residing at_____ authorize SOS Chiropractic , to furnish to my attorney named below, copies of any and all of my medical records or those of my children in references to illness of injuries, which were sustained on_____.

My signature below irrevocably assigns, authorizes and directs my attorney and all subsequent attorneys who may represent me to pay directly and promptly any and all of my outstanding balances with SOS Chiropractic from proceeds of any recovery resulting from a compromise, collection of judgment or monies received from any insurance benefits. I direct that my attorney shall not withhold any portion of the amount due to SOS Chiropractic and shall not disburse any other monies for expenses or attorney's fees until all outstanding balances at SOS Chiropractic are satisfied.

- I understand that payment for services not contingent upon recovery and that this does not relieve me of my personal, primary obligation to pay for services rendered.
- I also understand that I will be responsible for payment services rendered in the event that my attorney no longer represents me or I dismiss my attorney. Should I dismiss my attorney payment of service rendered will be due immediately. Delinquent payment of my balance will result in reasonable interest charges.
- I hereby waive my right to a trial by jury and agree to resolve any disputes through mediation.
- I hereby agree to waive the defense of the Statute of Limitations as it pertains to any claim filed against me beyond three (3) years or other statutory period after services rendered. I also understand that my balance remaining after three years will be charged a reasonable interest charge.
- It is understood that the signing of this form does not prohibit customary billing by SOS Chiropractic A photocopy of this agreement and authorization shall be binding as the original.

I agree to all of the above terms and further authorize my attorney to comply with the terms below.

Signature_____ Date_____

The undersigned attorney or Insurance Company agrees to the following:

- To comply with the authorization and assignment listed on the top of this document.
- To withhold and pay from proceeds from any settlement, collections of judgment, PIP, Med Pay, no fault or other insurance proceeds the amount of the doctor's charges and any other bills that are due this office after contacting with the office for the current balance.
- To advise within ten (10) days of the doctor's request the status of the above referenced claim.
- To notify the doctor immediately of any change in the status of the claim which may preclude payment of the doctor's charges.
- To require any attorney to whom the undersigned refers this case, within or outside the firm to honor this assignment as a condition of referral.
- To furnish home and work address information about the patient of family to aid in the collection of the bill.
- To understand this assignment of benefits shall remain in full force and effective until such time as all amounts due to SOS Chiropractic are satisfied in entirety notwithstanding any subsequent change(s) I make counsel representing me in my personal injury claim.

Signature of Attorney_____ Date _____

Printed Name of Attorney_____

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____ _____ _____

Print Name Signature Date

Consent to evaluate and adjust a minor child:

I, _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Doctor's Signature _____

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an X-ray evaluation. I have been advised that X-rays can be hazardous to an unborn child.

Date of last menstrual cycle:_____

_____ _____ _____

Print Name Signature Date

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:_____ **Last Name**:_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date:_____

Height: _____ Weight:_____ Blood Pressure:_____ /_____Temp:_____ Pulse:_____

PATIENT PRIVACY CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name: _____ Signature: _____ Date:_____

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patient:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.

SOS CHIROPRACTIC

Authorization for Release of Information

Patient Name:_____ Date of Birth:_____

Many of our patients allow friends or family members such as their spouse, parents or others to call and request medical and billing information. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's consent.

If you wish to have your medical or billing information released to someone, you must sign this form. Signing this form will only give information to the people listed below. Keep in mind individuals not listed will have **NO** information given to them in regards to your status at the office, appointment details and whereabouts.

Check here if you do not wish to share your information with anyone ❑

I authorize SOS Chiropractic to release my medical and/or billing information to the following individual(s):

Name_____ Relation to the patient:_____

Name _____ Relation to the patient:_____

Name _____ Relation to the patient:_____

Name _____ Relation to the patient:_____

Patient information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to re-disclosure by the above recipient.

You have the right to revoke this consent in writing.

Print Name:_____

Signature:_____ Date:_____

Modality Contraindications

PLEASE READ THE FOLLOWING INFORMATION REGARDING CONTRAINDICATIONS AND NOTIFY THE DOCTOR IF **ANY** OF THESE CONDITIONS APPLY TO YOU **OR IF YOU ARE UNSURE, PLEASE ASK!!! Please Circle any Contraindications that you have.**

A **contraindication** is a condition or factor that serves as a reason to withhold a certain medical treatment due to the harm that it would cause the patient.

The use of these machines is for symptomatic relief of chronic, intractable pain, muscle spasm and joint contractures.

Electrical Stimulation Contraindications

*Demand type cardiac pacemakers

*Use over cancerous lesions

Laser Therapy Contraindications

*Over abdomen during pregnancy

*Over pacemakers

*Over cancerous lesions

*Use on patients who are taking drugs that have heat or light sensitive contraindications (i.e. Steroids)

*Over epiphyseal plates in children

I,_____ have read the above statement and to the best of my knowledge, do not have any of the above listed contraindications to the use of electrical stimulation and Laser therapy.

❑ I do have a contraindication to one or more of the therapies listed above and have circled it to inform my doctor.

_____ _____

Signature Date

SOS CHIROPRACTIC
8991 Daniels Center Dr. #105
Ft. Myers, FL 33912

PHONE: 239-677-3593
FAX: 239-677-3576

AUTHORIZATION TO RELEASE INFORMATION

Hospital: _____Medical Records Department

Fax: _____ Phone: _____

Patient Name: _____

Date of Birth: _____

Date of Hospitalization: _____

SS#:_____ Treated in Emergency Room

****

THIS AUTHORIZATION INCLUDES THE RELEASE OF THE FOLLOWING INFORMATION:

**EMERGENCY ROOM RECORDS
**X-RAY REPORT/MRI
**DOCTORS REPORT

The purpose of the release of this information is to continue treatment.
I understand that I have to right to inspect and to receive a copy of the information to be disclosed and I may revoke this authorization at any time in writing, except to the extent that action has been taken based on the authorization.
I also understand that I may specify a date for the expiration of this authorization, but that it shall expire by law, without my express revocation, one year from the date written below, unless the patient is a resident of a nursing home. I direct that this authorization expire on_____.

PATIENT SIGNATURE_____ DATE:_____

If the patient is not able to provide consent for the release of information:

Authorized signature: _____Name:_____

Address: _____

APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your chiropractic care to SOS Chiropractic. When you scheduled an appointment with SOS Chiropractic we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment, as this gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy and description below:

Description

"No Show" shall mean any patient who fails to arrive for a scheduled appointment. "Same Day Cancellation" shall mean any patient who cancels an appointment less than 24 hours before their scheduled appointment.

Policy

If it is necessary to cancel an appointment, patients are required to call or leave a message at least 24 hours before their appointment time. Notification allows the practice to better utilize appointments for other patients in need of chiropractic care.

- Effective June 1, 2021 any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with at least **24 hours notice** will be considered a No Show and charged a $15 fee.
- Any established patient who fails to show or cancels/reschedules an appointment with no 24 hour notice a second time will be charged a $40 fee.
- If a third No Show or cancellation/reschedule with no 24 hour notice should occur the patient may be dismissed from SOS Chiropractic.
- The fee is charged to the patient, not the insurance company, and is due at the time of the patient's next office visit.
- We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our Office Manager, who may be able to waive the No Show fee. You may contact SOS Chiropractic 24 hours a day, 7 days a week at the number or email address listed below. Should it be after regular business hours Monday through Friday, or a weekend, you may leave a message.

I have read and understand the Appointment Cancellation/No Show Policy and agree to its terms.

_____ _____

Signature (Parent/Legal Guardian) Relationship to Patient

_____ _____

Printed Name Date