PACIFIC SPINE & SPORTS

DISCOUNTED TIME OF SERVICE FEES AND CANCELLATION POLICY

We would like to take a moment to welcome you to Pacific Spine & Sports and assure you that you will receive the very best care available!

In order to familiarize you with our financial policy we have provided the "Time of Service" outline below for your reference.

Service	Fee
CHIRO INITIAL EXAM OR RE-EXAM	$45
ADJUSTMENT FULL SPINE	$50
ESTIM OR ULTRASOUND	$15
ART/MYOFASCIAL RELEASE	$25 FOR 1 AREA
GRASTON TECHNIQUE	$25 FOR 1 AREA
CHIRO FULL TREATMENT: ADJUSTMENT, MYOFASCIAL RELEASE (1 AREA), MODALITIES, EXERCISE	$75
ACU INITIAL EXAM OR RE-EXAM	$45
CUPPING FOR 1 AREA	$50
ACUPUNCTURE FULL TREATMENT	$90
MASSAGE 1 HOUR	$85
MASSAGE ½ HOUR	$45

At Pacific Spine & Sports, we would like our patients to understand and acknowledge the time of service fees as outlined above. Reviewing this information will enable us to better serve you and help to avoid any misunderstandings in the future. **All** services are to be paid at the time of service unless special arrangements have been made in advance. Please read and sign this before your first consultation with the doctor.

PAYMENT OPTIONS

You may pay for your care with one of our convenient payment packages that will be discussed with you after you have met with the doctor and receive your personalized treatment plan.

CANCELLATION AND NO SHOW POLICY

Your appointment time is reserved for you in advance; however, we understand that situations arise in which you must cancel your appointment. Since Pacific Spine and Sports is committed to deliver excellent service to all our patients, we request that you notify us within **24 hours prior to your appointment** which enables other people to be scheduled in that time slot. There will be a $30.00 fee for all missed appointments without a 24-hour advance notice. Patients who do not show up for their appointment without a call to cancel at least 24 hours in advance will be considered as a "NO SHOW" and subject to a $65.00 fee for that appointment.

In the event your check is returned by your bank, for any reason, a charge of $25.00 for each dishonored check shall be made to your account.

I have read and agreed to the above statements regarding fees and office policies.

Patient signature: ___________________________________

Date: __________________