PATIENT POLICY

We believe that a clear definition of our patient policies will allow both, the patient, and the doctor, to concentrate on the issue at hand- **REGAINING AND MAINTAINING YOUR HEALTH.**

APPOINTMENTS: Office hours are available from 9am-6pm Tuesday and Thursday, 9am-2pm Monday and Friday and 9am-12 noon on Saturday, unless otherwise stated.

Multiple appointments have been scheduled for your convenience to minimize waiting and to incorporate these appointments into your weekly routine.
We strive to honor all appointments at the scheduled time. If you are late, you may have to wait for the next available appointment.

MISSED/CANCELLED APPOINTMENTS: It is a **new** policy of this office to charge for late cancelled appointments and no shows. Changes or cancellations must be made at least 24 hours in advance as your appointment time is reserved exclusively for you**.**
A fee of $25.00 (twenty-five dollars) will be charged for any late cancelled appointments and $30.00 (thirty dollars) for No-Shows.

****Please be informed that insurance carriers do not cover charges related to missed or late appointments.**

EMERGENCY APPOINTMENTS/ SERVICE: In case of life threatening emergencies, please contact 911 for immediate attention. You can leave a message on the office voicemail for Dr. Alonso, and all calls will be returned as promptly as possible.

CONSENT FOR TREATMENT

The undersigned hereby consent to the treatment by Dr. Jennifer Alonso, her associates and/or assistants, of the below-named patient, including chiropractic care, modalities, appliances, and/or procedures, prescribed, or necessarily related to prescriptions, by patients Doctor of Chiropractic. I understand and am informed that as in the practice of medicine, in the practice of chiropractic, there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to reply on the doctor to exercise judgment during the course of the procedure, which the doctor feels at the time, based on facts then known, is in my best interest.

CONSENT TO TREAT A MINOR

I am the parent, guardian, or personal representative of (child/minor's name)_____ and there are no court orders now and effect that prohibit me from signing this consent. I do hereby request and authorize the doctor and practice staff to perform necessary services for the child named above, including any treatments, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

Your signature below indicates that you have read the information in this document and agree to abide by its terms while a patient here at Optimal Wellness Chiropractic.

_____ _____

Signature of Patient and/or Parent/Guardian **Date**