

24 HOUR NOTIFICATION POLICY
Applies to Chiropractic and Massage Therapy services

At Orinda Family Chiropractic we have chosen to emphasize quality of chiropractic care, massage therapy care and health services for our clients. Due to our dedication to your health care, we often have a waiting list for treatment at certain appointment times. If you **fail to maintain your appointment** or reschedule **after 24 hours**, this can deprive patients on our waiting list of an opportunity to receive care from the doctor. We need your help with this! If for some reason, you are unable to maintain or need to reschedule your appointment we must have 24 hours notification prior to the appointment in order to best assist those who may be in need of our services.

I _____ do agree to give the office notification of appointment rescheduling or change 24 hours notice prior to my scheduled appointment. I understand that **I am responsible** for notification and that if, for circumstances excluding emergencies I am unable to notify or fail to maintain my appointment that **I will be charged a fee of \$60.00. This charge will be charged directly to my credit card listed below.**

Or

I _____ do agree to give the office notification of appointment rescheduling or change 24 hours notice prior to my scheduled appointment. I understand that **I am responsible** for notification and that if, for circumstances excluding emergencies I am unable to notify or fail to maintain my appointment that **I will be charged a fee of \$60.00. I am providing Orinda Family Chiropractic with a check in the amount of \$60.00 and giving permission to cash it in the event I fail to keep my appointment or give less than 24 hour notice of cancelling or rescheduling prior to m scheduled appointment.**

Check # _____ Amount \$60.00

Thank you for your help. We appreciate your understanding and support.

Patient's Signature: _____ Date: _____

Patient's Name Printed: _____

If minor, Guardian's Signature: _____ Date: _____

Guardian's Name Printed: _____

Card Type: Visa MasterCard ATM

Card # _____ Expiration date: _____

Signature of card holder: _____