ADVANTACARE CHIROPRACTIC WELLNESS CENTER

Chiropractic ~ Application for Patient Care

PATIENT INFORMATION

First Name: ________________________ M.I.: ____ Last Name: _____________________ Gender M / F

What do you prefer to be called? _____________SS#:_____-_____-______ DOB: __ __ /__ __ /__ __

Mailing Address: ____City/State/Zip: ___________________________

Cell Phone: (_____) _____-________ Home Phone: (_____) _____-________

Email: ____ Preferred Language: _______________

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / Other / Decline to Answer **Ethnicity (Circle one)**: Hispanic or Latino / Not Hispanic or Latino / Decline to Answer

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Minor

Do you have children? ____Yes ____No # of Children? _____ Children's Ages: ________________

Is there anyone else in your family, a loved one or friend that could benefit from our care? __________________

EMPLOYMENT

Employment Status: ☐ Employed ☐ Unemployed ☐ Retired ☐ Student ☐ Volunteer ☐ Other

Business Name: _____________________________Occupation / Job Title: _____________________________

Type of Tasks Performed/Common Movements: ____

EMERGENCY

Emergency Contact Name: _____________________________ Relationship to you: __________________

Address: ____ Phone #: (_____) _____-________

Primary Care Physician: ____

Do we have permission to contact your doctor regarding your care in our office? ____Yes ____No

ACCIDENT

Have you had an auto accident? (X if applies): ☐ 0-6mo ☐ 6 mo-1 yr ☐ 1-3yrs ☐ 3+yrs ☐ Never

Had a recent fall/other accident? (X if applies): ☐ 0-6mo ☐ 6 mo-1 yr ☐ 1-3yrs ☐ 3+yrs ☐ Never

Have You Ever Received: ☐ Physical Therapy ☐ Chiropractic Care ☐ Pain Management? Last Visit: ______

REFERRALS

How Did You Hear About This Office?

☐ Existing Patient: ___________________________

☐ Employee Referral: _________________________

☐ Physician Referral: __________________________ ☐ Other: ________________________

INSURANCE

Do you have health insurance? ☐ Yes ☐ No Name of Carrier: _________________________________

Member ID/Policy #: ______________________________

Do you have secondary insurance? ☐ Yes ☐ No Name of Carrier: _________________________________

Member ID/Policy #: ______________________________ Group #: ________

PRIMARY INSURED: All of the following information is about the INSURANCE HOLDER

Name of Insured: ___________________________ DOB of Insured: ____/____/_______

Relationship to you (the patient):________________ Employer: ______________________________

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

Signature (X) ______________________________ Date________________

ADVANTACARE CHIROPRACTIC WELLNESS CENTER

Patient Name: ____________________________________ Date: __________________

PRIMARY COMPLAINTS: **Please list in order of most severe (#1) to least severe (#4).** *Sample complaints: Low Back, Left Knee, Right Shoulder, Neck, etc.*

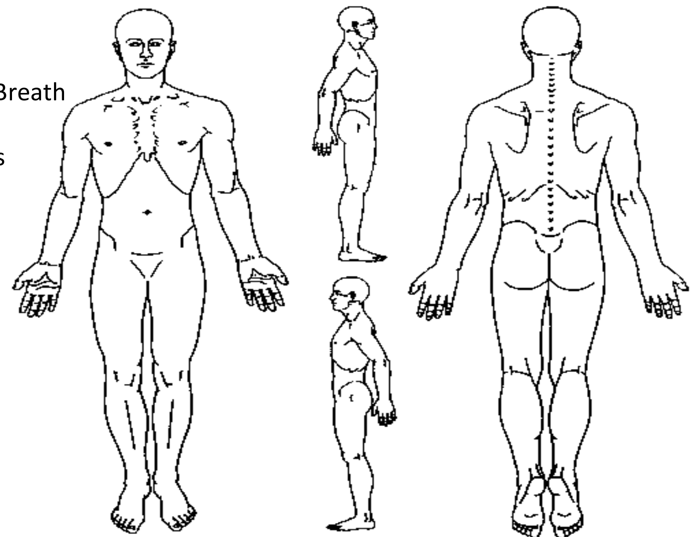
MOST SEVERE ◄────────────────────────► **LEAST SEVERE**

You have the following complaints (WRITE-IN)	1.	2.	3.	4.
Circle the word that best describes this complaint.	Sharp dull achy throbbing numb shooting other	Sharp dull achy throbbing numb shooting other	Sharp dull achy throbbing numb shooting other	Sharp dull achy throbbing numb shooting other
How often do you feel this complaint?	Constant Daily Weekly "Off and On"	Constant Daily Weekly "Off and On"	Constant Daily Weekly "Off and On"	Constant Daily Weekly "Off and On"
How long have you had this complaint?	____ Days / Weeks / Months / Years	____ Days / Weeks / Months / Years	____ Days / Weeks / Months / Years	____ Days / Weeks / Months / Years
Is it getting better, worse, or staying the same?	Better Worse Same	Better Worse Same	Better Worse Same	Better Worse Same
What makes it better, if anything?				
What makes it worse, if anything?				
On a scale of 0 – 10, rate your discomfort. ***(0 = no pain, 10 = excruciating)***	**Circle response** 0 1 2 3 4 5 6 7 8 9 10	**Circle response** 0 1 2 3 4 5 6 7 8 9 10	**Circle response** 0 1 2 3 4 5 6 7 8 9 10	**Circle response** 0 1 2 3 4 5 6 7 8 9 10
How have you taken care of this in the past? Has that worked for you?				
Circle the ways this issue is affecting your life. *(all that apply)*	job children sex marriage household hobbies finances sports exercise walking standing bowels urinary fatigue loss of sleep moody poor attitude loss of productivity	job children sex marriage household hobbies finances sports exercise walking standing bowels urinary fatigue loss of sleep moody poor attitude loss of productivity	job children sex marriage household hobbies finances sports exercise walking standing bowels urinary fatigue loss of sleep moody poor attitude loss of productivity	job children sex marriage household hobbies finances sports exercise walking standing bowels urinary fatigue loss of sleep moody poor attitude loss of productivity
Improving this issue in my life would improve my quality of life by: *(Circle best response)*	10-20% 30-40% 50-60% 70-80% 90% 100%	10-20% 30-40% 50-60% 70-80% 90% 100%	10-20% 30-40% 50-60% 70-80% 90% 100%	10-20% 30-40% 50-60% 70-80% 90% 100%

PATIENT HEALTH HISTORY

Please check if you are currently experiencing any of the following conditions and then circle problematic areas on body to right:

- ❑ Neck Pain/Stiffness
- ❑ Back Pain/Stiffness
- ❑ Arm/Hand Pain
- ❑ Leg/Knee Pain
- ❑ Headaches
- ❑ Cold Extremities
- ❑ Sleeping Difficulties
- ❑ Dizziness
- ❑ Foot Trouble
- ❑ Pins/Needles in Arms
- ❑ Pins/Needles in Legs
- ❑ Fatigue
- ❑ Recent Weight Change
- ❑ Chest Pain
- ❑ Bowel/Bladder Changes
- ❑ Jaw Problems
- ❑ Blurred/Double Vision
- ❑ Loss of Balance
- ❑ Shortness of Breath
- ❑ Night Pain
- ❑ Swollen Joints



2902 Dolphin Dr. Elizabethtown, KY 42701 Phone (270.769.2255) Fax (270.763.9773
Dr. Craig A. Bartelt, D.C.

ADVANTACARE
CHIROPRACTIC WELLNESS CENTER

Patient Name: ________________________________ Date: ________________

PATIENT HEALTH HISTORY continued….

Please check if you have ever had any of the following:

- ❑ Alcoholism
- ❑ Ankle Pain/Stiffness
- ❑ Arthritis
- ❑ Cancer
- ❑ Circulation Problems
- ❑ Degenerative Disc
- ❑ Diabetes
- ❑ Fibromyalgia
- ❑ Fractures
- ❑ Gout
- ❑ Hand/Wrist Pain
- ❑ Headaches
- ❑ Herniated Disc
- ❑ Hip Pain/Stiffness
- ❑ Hip/Knee/Shoulder Replacement
- ❑ Implanted Device: ________________
- ❑ Knee Pain/Stiffness
- ❑ Low Back Pain/Stiff
- ❑ Mid Back Pain/Stiff
- ❑ Upper Back Pain/Stiff
- ❑ Migraines
- ❑ Multiple Sclerosis
- ❑ Numbness/Tingling Arm
- ❑ Osteoporosis
- ❑ Pain Radiating – Arm
- ❑ Pain Radiating – Leg
- ❑ Pain w/coughing
- ❑ Pain w/sneezing
- ❑ Pinched Nerve
- ❑ Rheumatoid Arthritis
- ❑ Shoulder Pain / Stiffness
- ❑ Spinal Surgery
- ❑ Stroke
- ❑ TMJ Pain
- ❑ Genetic Disorder: ________________
- ❑ NONE

❑ Other Disorder/Disease/Device/Implant/Surgical Hardware or Medical Condition not mentioned above:__________________

Please list any and all medications you are currently taking: ____

____

Please list any surgeries and/or hospitalizations you have had (type & date): ____

____

Please list any supplements you are currently taking (vitamins/herbs/minerals): ____

Is there a family history of any of the following conditions? *(indicate family member including parents, grandparents & siblings)*

❑ Heart Disease_________________ ❑ Diabetes ________________

❑ Cancer ______ ________________ ❑ Arthritis _________________ ❑ Other ___________________________

Do you exercise: ❑ 5-7x/week ❑ 3-4x/week ❑ 1-2x/week ❑ Occasionally ❑ None

Do your work activities mostly involve: ❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor

Do you sleep on your: ❑ Back ❑ Side ❑ Stomach

What is your daily/weekly intake of the following:

Caffeine ____ cups/day Alcohol ____ drinks/week Cigarettes/ Vape _____ pks/day

Smoking Status: Never smoked / Former Smoker / Occasional Smoker / Daily Smoker

I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health. I will give complete & accurate information during my exam.

Signature (X) ____ Date_______________

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Dr. Craig A. Bartelt, D.C.

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Patient Name: ____________________________________ Date: __________________

TERMS OF ACCEPTANCE AND CONSENT FOR CARE

Kentucky State Law requires health care providers to obtain your **INFORMED CONSENT** prior to examination and treatment. The purpose of this form is to inform you, not to alarm you. What you are being asked to sign is a confirmation that you have been informed of the following:

Chiropractic Adjustment/ Chiropractic Manipulative Therapy (CMT): The doctor will use his hands or a mechanical device upon your body in such a way as to move your joints in various directions. This procedure may cause an audible "pop" or "click" to be heard coming from your joints, which is not cause for alarm.

There are some material risks involved in doing these procedures as follows:

►**Pain:** Chiropractic Manipulation, Massage Therapy, Modalities (such as Electrical Stimulation, Ultrasound, Cold Laser Therapy, etc.), or other treatments may result in a temporary increase in soreness in the area receiving treatment.

►**Rib Fractures:** Fractures caused by chiropractic treatments are rare. They occur most frequently in patients with osteoporosis or weakened bones. Evidence of osteoporosis can be noted on your x-rays, and if detected, the most appropriate, gentle treatments are used, minimizing the possibility of fractures to the ribs.

►**Disc Injury:** Chiropractic treatment is appropriate for the treatment of many kinds of back problems, including some disc problems (1). Occasionally, chiropractic treatment may aggravate or cause a problem if the disc is in a severely weakened state. However, this occurs so rarely that statistics to quantify the probability are unavailable, but estimates place the risk of serious injury at *about 1 serious complication per 100 million low back manipulations* (2).

►**Vertebral Artery Dissection (VAD)/Stroke:** The overall incidence of vertebral artery dissection/stroke in the general population is about *2 per 1000 people* (3). Although chiropractic adjustment/manipulation has been implicated as a possible cause of stroke, this possibility is extremely rare. The best available data suggests that stroke secondary to chiropractic adjustment/manipulation may occur *1 per 100,000 patients* (4)-a rate well below the overall average risk in the general population. In comparison, the overall average risk of death from taking non-steroidal anti-inflammatory drugs (i.e. Aspirin, Ibuprofen, Naproxen Sodium, etc.) is *4 per 10,000 patients* (5). The risk of serious complications or death from spine surgeries of the neck is *11.25 per 1000 patients* (5). As you can see, the risk of stroke from chiropractic treatments is much lower than other common medical treatments. Even though the risk is small, we have implemented procedures and tests that will likely reduce the potential for stroke even more.

►This list is of side-effects IS NOT EXHAUSTIVE and there could be other negative side-effects of various treatments rendered in this office.

Initial: ________

I understand the risks and possible negative side effects of Chiropractic Care, Massage Therapy, and other therapeutic modalities and treatments at ADVANTACARE Chiropractic Wellness Center that are involved in my treatment, and I have had the chance to ask questions of the doctor and staff regarding these procedures and make an informed decision in the treatment of my condition(s). I understand the risks associated with such treatments but wish to be treated nevertheless for my condition(s). By initialing these sections and signing this statement I authorize Dr. Bartelt and any or all members of the ADVANTACARE Chiropractic Wellness Center Staff to treat me using the methods designed by Dr. Bartelt/other doctors working for ADVANTACARE Chiropractic Wellness Center.

Initial:________

Chiropractic is a second largest system of health care delivery. As with any health care delivery system, we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this office. We will always give you our best care, and if your results are not acceptable, we will refer you to another health care provider who we feel will assist your situation.

X-ray Questionnaire: For women only Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: ____________________________________ Date of last menstrual period: __________________

☐ There is a possibility that I may be pregnant at this time ☐ Yes, I am definitely pregnant

☐ No, I am definitely not pregnant at this time ☐ I request that x-ray films not be taken because: ____________

I, ___________________________ have read and fully understand the above statements.

Patient Signature: ____________________________ SSN: _____________________ Date: ____/____/_____

2902 Dolphin Dr. Elizabethtown, KY 42701 Phone (270.769.2255) Fax (270.763.9773

Dr. Craig A. Bartelt, D.C.

ADVANTACARE CHIROPRACTIC WELLNESS CENTER

Patient Name: ____________________________________ Date: __________________

ASSIGNMENT & RELEASE

I understand that chiropractic is manual health care and requires direct contact between the doctor /staff & patient.
I understand I must keep my account current at all times unless prior arrangements have been made.
I authorize release of information to family physicians, health specialists and employer(s).
I authorize release of information to insurance companies.
I authorize the taking of photographs and x-rays to be used for treatment purposes.
I authorize the performance of other diagnostic and therapeutic procedures for treatment purposes.
I understand that the doctor may want my x-ray films or other tests/results read by Radiologists or other specialists and I will be charged a fee for that reading.
I authorize Dr. Bartelt to speak with and share my health information regarding my case with other doctors as he deems necessary.

I authorize my insurance benefits to be paid directly to:

ADVANTACARE Chiropractic Wellness Center
Craig A. Bartelt, D.C.
2902 Dolphin Drive Elizabethtown, KY. 42701
(270) 769-2255

I acknowledge that I am financially responsible for ALL SERVICES provided to me for treatment (both covered and for non-covered services), as insurance benefits are a contract between myself and my insurance company (health, auto, etc.) and not the doctor (health care provider), and according to insurance companies your benefit coverage is not guarantee of payment for services rendered. I also understand that if I terminate my care and treatment, any fees for professional services rendered me will be **IMMEDIATELY** due and payable.

I understand payment for the first day's services is due at the completion of my first office visit unless prior arrangements have been made.

I HAVE BEEN INFORMED OF THE MOST LIKELY COMPLICATIONS OF THE POSSIBLE UNDESIRABLE RESULTS OF CHIROPRACTIC EXAMINATION, MASSAGE THERAPY AND OTHER TREATMENTS AND MODALITIES IN THIS OFFICE AND I UNDERSTAND THEM FULLY.

I hereby authorize and direct *Dr. Bartelt and his associates or assistants* to provide services as they deem reasonable and necessary.

I HEREBY STATE THAT I HAVE READ-OR HAVE HAD SOMEONE READ TO ME-THIS CONSENT FORM.

- **PATIENT**

I, ___________________________ have read and fully understand the statements on this document.

______________________________ ______________________________ ______________________

(PRINTED NAME) (SIGNATURE) (DATE)

- **MINOR CHILD**

I, ___________________________ being the parent or legal guardian of _________________________,
(Print Guardian Name) ***(Print Minor's Name)***
have read and fully understand the above terms of acceptance & grant permission for my child to receive treatment.

______________________________ ______________________

(GUARDIAN SIGNATURE) (DATE)

- **EMPLOYEE WITNESS:**

______________________________ ______________________________ ______________________

(EMPLOYEE PRINTED NAME) (SIGNATURE) (DATE)

Patient Name: ___________________________________ Date: _________________

HIPAA PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at ADVANTACARE Chiropractic Wellness Center, we may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including your clinical records, may be disclosed to another healthcare provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your healthcare records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.
- Your name, address, phone number, and healthcare records may be used to contact you regarding appointment reminders, information about alternative to your present care, or other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Furthermore, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

- If we are providing healthcare to you based on the orders of another healthcare provider.
- If we provide healthcare services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain our consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or discloser of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your healthcare or about the status of your account. If you would like to receive this information at an address other than your home or if you would like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend our health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the Information that we use or disclose based on this privacy notice may be subject to re-discloser by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to: MONICA BARTELT. If you would like further information about our privacy policies and practices please contact: MONICA BARTELT at 270.769.2255.

This notice is effective as of August 1, 2024. This notice, and any alterations or amendments made hereto will expire seven (7) years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

______________________________ ______________________________ ________________

Name (Print) **Signature** **Date**

ADVANTACARE
CHIROPRACTIC WELLNESS CENTER

Patient Name: ______________________________ Date: ______________

Insurance Assignment Agreement

PATIENT NAME: ____ **ID#** _____ - _____ - _______

INSURANCE COMPANY/INFO: ____

This office is pleased to accept your case on assignment as soon as your insurance company and or the responsible party confirm your eligibility. Our office agrees to file your claim forms to assist you in every way we can for reimbursement. ***However, we must make it clear that insurance contracts are between you as the patient and your insurance company;*** YOU ARE RESPONSIBLE FOR ANY AMOUNT NOT PAID BY YOUR INSURANCE COMPANY.

Please be aware that ***it is ultimately the patient's responsibility to be aware of and understand their own coverage, benefits, and Health Insurance Policy as a whole and whether the provider you choose is in your network, if applicable.*** By accepting your health insurance on assignment, we are extending you credit. This courtesy may be withdrawn if circumstances below warrant. All of the following lines are applicable to your agreement unless blank.

It is imperative that you understand these conditions and agree to them:

1. You are required to sign informed consent and medical records release forms as well as any other assignment documents required by this office and your insurance-company or we cannot treat you.
2. **Co-pay/Co-Insurance, deductible payments and fees for non-covered services are due at time of service per your insurance company.**
3. Your insurance company should provide an **Explanation of Benefits** (**EOB**) to our office and to you as the patient within 30 days of your office visit. **If your insurance has not paid within 45 days, then you will be responsible to pay the balance due, and if not paid within 60 days the account is considered within default.** You are responsible for all fees resulting in and associated with the collection of any outstanding balance including but not limited to attorney's fee, service charges, and/or staff wages/time.
4. **Your insurance company does not guarantee that they will pay for services provided even though you have the benefits available, therefore if your insurance claim is denied, you are responsible for the full amount of your balance immediately.** Any past due accounts are subject to a 1.5% per month service charge or 18% annually. Returned checks are subject to a $25.00 administrative fee.
5. Our office will not enter into a legal dispute with your insurance company over any claim. This is ultimately your responsibility and obligation.
6. If you choose to discontinue your treatment plan or dismiss yourself from care against medical advice you may be required by your insurance company to pay for your care at your own expense.
7. **☐ I AM on Medicare _______ Pt. Initials ☐ I AM NOT on Medicare_______ Pt. Initials ☐ I WILL INFORM ADVANTACARE as soon as I am on Medicare _______ Pt. Initials ****Note: When on Medicare I will be required to fill out an Advance Beneficiary Notice (ABN) Form per Medicare Guidelines**
8. **I understand the insurance definitions: *Co-Pay*, *Co-Insurance*, and *Deductible* (*Definitions on Side 2*) and how they apply to my services & billing, and all my questions have been answered to my satisfaction.**

If you understand and agree with all the above policies, sign your name below and we will accept your insurance assignment as stated above.

______________________________ ______________________________ ____/____/2025
Patient's Signature **Print Name** *Date*

______________________________ ______________________________ ____/____/2025
Office Authorizing Signature **Print Name** *Date*

INSURANCE DEFINITIONS (Per Side 1 No. 8)

____/____/2025
Date

Co-Payment [Co-Pay]: A copayment or **copay** is a fixed amount for a covered service, paid by a patient to the provider of service before receiving the service. It may be **defined** in an **insurance** policy and paid by an insured person each time a **medical** service is accessed. **Copayment Example:** A fixed amount ($20, for **example**) you pay for a covered **health** care service ***after you've paid your deductible***. Let's say your **health insurance** plan's allowable cost for a doctor's office visit is $100. Your **copayment** for a doctor visit is $20. ***Before the deductible is met all services must be paid in full, thereafter the only amount payable would be the co-pay or as directed by your insurance company.***

Co-Insurance: The percentage of costs of a covered **health** care service you pay (20%, for **example**) ***after you've paid your deductible.*** Let's say your **health insurance** plan's allowed amount for an office visit is $100 and your **coinsurance** is 20%. If you've paid your deductible: You pay 20% of $100, or $20. The amount of co-insurance is based on the amount of services provided on each date of treatment and may vary based on services rendered.

Deductible: The amount you pay for covered **health** care services before your **insurance** plan starts to pay for any care you receive. With a $2,000 **deductible**, for example, you pay the first $2,000 of covered services yourself (an out of pocket expense that you set up per your plan with your health insurance company). After you pay your **deductible**, you usually pay only a copayment or coinsurance for covered services per your insurance plan.

I understand the definitions above as they pertain to my own insurance policy. ***Patient Initials:*** ______

ADVANTACARE Chiropractic & Massage Therapy Missed Appointment Policy

Due to increases in missed appointments for both Chiropractic/Rehabilitation and Massage Therapy Treatments our office has instituted a **"Missed Appointment Fee."** (*See Missed Appointment Definition Below****).

If you miss a **Massage Therapy Appointment** without Proper Cancellation you will be required to pay a Missed Appointment Fee of:

►$35.00 for a 30 Minute Missed Massage Appointment
►$50.00 for a 1 Hour Missed Massage Appointment
► For each 30 minutes after the first hour of a Missed Massage Appointment (if the appointment is for longer than standard 30 min/60 min times) the fee is added additionally based on the on the fee for the 30 Minute and/or the 60 Minute Missed Appointment Fee (whichever is less).
►**Note:** This policy also applies to ADVANTACARE Massage Maintenance Program (AMMP) Appointments for Massage Therapy Services (not Chiropractic Manipulative Therapy [CMT]/Adjustments) under AMMP.
If you only want ***"As Available"*** Massage Therapy, then you will not receive any priority for Massage Therapy Care and will only be able to receive care if there is an available appointment time when you come into the office. I realize if I choose this option getting care with Massage Therapy will be very difficult.

If you miss a **Chiropractic Therapy Appointment** (without Massage Therapy Services) & without Proper Cancellation you will be required to pay a Missed Appointment Fee of: **$25.00 (after the 2nd Missed Appointment [3-Strikes Policy for Chiropractic Services ONLY and NOT Massage Therapy] because we understand things happen. Note: if that missed appointment also includes a Massage Therapy appointment – you will get charged BOTH FEES!**

I understand and will comply with the above/below Missed Appointment Policy. ____________
Patient Initials:

*****MISSED APPOINTMENT DEFINITION:** *Missing an appointment that has not been cancelled 24 HOURS PRIOR to the DATE/TIME of Scheduled Service (by TALKING with an ADVANTACARE Staff Member).*
NOTE: Voicemails/Phone Messages, e-mails, Facebook/Web Messages, or sticky notes on the outer door of the office DO NOT COUNT as a CANCELLATION. A staff member must get the message at which time they will note it in your Patient Chart as a ***Missed Appointment***, and you will be required to pay a Missed Appointment Fee as noted above.