MICHAEL C. POLSON, D.C.

Polson Family Chiropractic

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OFFICE POLICY

(Initial)___ **MISSED** APPOINTMENT POLICY: The fee for "No Show" of a scheduled appointment is $20.00. Please call 2 hours in advanced to reschedule and avoid being charged.

(Initial)____ RETURNED CHECK POLICY: Returned check fee is $20.00.

(Initial)____ MEDICAL RECORDS AND X-RAYS: X-rays performed and medical records generated are property of Polson Family Chiropractic. With your written request a copy will be sent to any doctor's office, fee to copy most recent X-rays $50.00 or $10.00 per film. X-rays will be sent as soon as payment is received. Fee to copy medical records $25.00.

(Initial)____ I ACCEPT FULL RESPONSIBILITY FOR PAYMENT OF ALL FEES ASSOCIATED WITH MY TREATMENT AND ALL COSTS IN COLLECTION OF SAID FEES.

(Initial)____ I UNDERSTAND NO GUARANTEE OR WARRANTY HAS BEEN MADE TO ME THAT RESULTS WILL BE TO MY COMPLETE SATISFACTION.

(Initial)____ UPON MY TERMINATION OF TREATMENT, I WILL PAY ANY REMAINING BALANCE DUE IN FULL IMMEDIATELY.

(Initial)____ I GIVE DR. POLSON LIMITED POWER OF ATTORNEY TO ENDORSE THE PATIENTS NAME UPON PAYMENTS RECEIVED.

I HAVE READ THE ABOVE, UNDERSTAND AND CONSENT TO TREATMENT.

Signature: _____ Date: _____

Witness: _____