

# CLAYTON FAMILY CHIROPRACTIC CLINIC

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## APPOINTMENT CANCELLATION POLICY

We want to thank you for choosing us as your chiropractic health provider. We strive to render excellent care to you and the rest of our patients. Your care and treatment are a priority to us. We also ask that you respect your chiropractor's time and experience as well.

In an attempt to be consistent with this, we have an "Appointment Cancellation Policy" that allows us to schedule appointments for our patients, with respect for your time, the next patient's time, and the doctor's time.

### **Our policy is as follows:**

We request that you give 24 hours notice in the event that you cannot make it to your scheduled appointment. This will enable us to offer your cancelled time to other patients that desire to get their treatment completed. If a patient misses an appointment without contacting our office, it is considered a "missed" or "no show" appointment. (With exceptions to emergencies)

- **Your first initial exam requires a \$50.00 deposit that will go to your balance at the end of your appointment. If you miss this appointment without a 24-hour notice, your deposit will go toward your missed appointment fee of \$50.00.**
- **Any missed appointment, after your first initial exam, will be a \$45.00 missed appointment fee.**
- **Additionally, if you miss more than THREE (3) appointments, Dr. Vail reserves the right to discharge you from the practice for failing to follow treatment recommendations.**
- **Also, if you any have therapy scheduled, on the same day as your appointment, you will be responsible for those fees as well.**
- **Cancellation fees ARE NOT covered by your insurance.**
- **All fees must be paid in full at your next appointment.**

If you have any questions regarding this policy, please let my staff know, and we will be happy to clarify the policy for you.

We look forward to being a continued part of your wellness.

**I have read and understand the "Appointment Cancellation Policy" of Clayton Family Chiropractic Clinic, and I agree to be bound by its terms.**

I, \_\_\_\_\_, have received a copy of Clayton Family Chiropractic Clinic's "Appointment Cancellation Policy".

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness