

PATIENT RESPONSIBILITIES

Your co-pay is due at the time of service unless other arrangements have been made.

Please be advised that we collect a \$50 no show fee if you have not given us 24 hours notice of cancellation for trigger point therapy and massage.

You will be personally responsible for this payment.

I, _____, a patient being treated at Alta Vista Chiropractic do hereby acknowledge that a certain portion of my care may not be covered by my health plan.

I understand and agree to be responsible to self-pay for the following services:

LIST OF SERVICES TO BE PAID FOR BY MEMBER:

Procedure:	Charge:
Massage Therapy codes not covered by Insurance	\$
	\$
	\$
	\$
	\$

I acknowledge that I have been told in advance of treatment what portion of my care I will have to pay for.

Patient's signature: _____ Date: _____
(Guardian must sign for all patients 17 years or younger)

Witness: _____ Date: _____

If you have any questions or concerns, please ask at the front desk.