CUMMING CHIROPRACTIC CENTER

PATIENT INTRODUCTION CARD

Date_____

Name_____Social Security#_____
Last First Middle

Address_____City_____State_____Zip_____

Home #_____ Cell #_____ Work #_____

Who is your primary care physician? _____ Phone # _____ Last Appt _____

Email address_____

Age_____Birthdate_____ #Children/Ages_____ Marital Status M S W D

Occupation_____ Employer_____

Spouse's Name_____DOB_____SS#_____

Emergency Contact Name_____Phone_____ Relation_____

Do you have health insurance?_____ What company?_____

Describe health concerns in detail, how it happened and your pain level (mild 1 2 3 4 5 6 7 8 9 10 severe)

_____

_____

How has this affected your Activites of Daily Living?_____

_____

Date symptoms occurred?_____ Ever had similar symptoms? ❑ Yes ❑ No

Is condition related to auto accident? ❑ Yes ❑ No Employment? ❑ Yes ❑ No Referred by_____

What aggravates condition?_____What makes condition better? _____

Describe care received before coming to this office and results_____

_____

Have you had chiropractic before?_____ Where?_____When?_____

Do you wish spinal correction or temporary relief of your condition? ❑ Correction ❑ Temporary Relief

Have you ever had surgery? ❑ Yes ❑ No If yes, please explain (give month & year) _____

_____

Are you presently taking any medication? ❑ Yes ❑ No If yes, please give type, dosage and what it is for _____

_____

Have you ever had any falls, accidents or injuries? ❑ Yes ❑ No If yes, please explain (give month & year)_____

_____

Describe injured area(s)_____

_____

Patient Name: _____ ID#: _____

Date: _____

REVIEW OF SYSTEMS

Please write in a number: 1. PRESENTLY HAVE; 2. PREVIOUSLY HAD; 3. DUE TO CURRENT INJURY (Date:_____)

GENERAL
___Cancer
___Stroke
___Broken Bones
___Cortisone Use
___High Blood Pressure
___Siezures / Eplepsy
___Diabetes
___Headache
___Dizziness/Fainting
___Unexplained Weight Loss
___Drug or Food Allergy
___Excessive Thirst
___Constant Fatigue
___Night Sweats
___Tremors

EYES, EARS, NOSE, THROAT
___Asthma
___Colds
___Sore throat
___Deafness
___Dental decay
___Earache/Frequent Ringing in Ears
___Ear discharge
___Sinus infection
___Enlarged glands
___Enlarged thyroid
___Nose bleeds
___Worsening vision
___Far sighted
___Gum trouble
___Hay fever
___Hoarseness
___Nasal obstruction
___Near sighted

MUSCULOSKELETAL
___Arthritis
___Bursitis
___Tendonitis
___Hernia
___Low back Pain, Soreness or Stiffness
___Mid-Back Pain, Soreness or Stiffness
___Neck Pain, Soreness or Stiffness
___Shoulder Blade Pain, Soreness or Stiffness
Pain or numbness in:
___*Shoulders*
___*Arms*
___*Elbows*
___*Hands*
___*Hips*
___*Legs*
___*Knees*
___*Feet*
___Painful tailbone
___Poor Posture
___Sciatica
___Scoliosis

GENITO-URINARY
___Urgent Sensations to Urinate
___Blood in urine
___Frequent urination
___Inability to control bladder
___Kidney infection or stones
___Painful urination
___Prostate trouble
___Pus in urine
___Painful menstruation
___Hot flashes
___Irregular Menses
___Lumps in Breasts

CARDIOVASCULAR
___Hardening of arteries
___Low blood pressure
___Dizziness
___Pain over heart
___Poor circulation
___Rapid heart beat
___Slow heart beat
___Swelling of ankles

RESPIRATORY
___Chest pain
___Chronic cough
___Difficult breathing
___Spitting up blood
___Spitting up phlegm
___Wheezing

GASTROINTESTINAL
___Belching or gas
___Colitis
___Colon trouble
___Constipation
___Diarrhea
___Difficult digestion
___Distention of abdomen
___Excessive hunger
___Gall bladder trouble
___Hemorrhoids
___Intestinal worms
___Jaundice
___Liver trouble
___Nausea
___Pain over stomach
___Poor appetite
___Vomiting
___Vomiting blood

OTHER

_____

_____

_____

_____

_____

Employment, Activities of Daily Living (ADL's) and Recreation Information

Patient Name: _____ Date: _____

Description of Work: _____

Condition's Effect On Job Performance:

☐ No Effect ☐ Mild Painful (Can do) ☐ Mod Painful (Limited) ☐ Severe (Unable to Perform)

Daily Activities: Effects of Current Condition on Performance

Bending:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Care- Infirm Family:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Carrying Groceries:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Change Pstn Sit to Stand:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Climb Stairs:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Driving:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Extended Computer Use:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Feeding:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Household Chores:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Kneeling:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Lift Children:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Lifting:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Pet Care:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Reading (Concentration):	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Self Care Bathing:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Self Care Dressing:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Self Care Shaving:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Sexual Activities:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Sleep:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Static Sitting:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Static Standing:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Walking:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
Yard Work:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)

Recreational Activity: Effects of Current Condition on Performance

_____	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
_____	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)
_____	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Severe (Unable to Perform)

(Examples: running, golfing, bowling, tennis, shopping, water sports, cycling, football, basketball, weight train, aerobics, biking, swimming, hunting, fishing, gardening, etc.)

Neck Disability Index

THIS QUESTIONNAIRE IS DESIGNED TO HELP US BETTER UNDERSTAND HOW YOUR **NECK PAIN** AFFECTS YOUR ABILITY TO MANAGE EVERYDAY -LIFE ACTIVITIES. PLEASE MARK IN EACH SECTION THE **ONE BOX** THAT APPLIES TO YOU.
ALTHOUGH YOU MAY CONSIDER THAT TWO OF THE STATEMENTS IN ANY ONE SECTION RELATE TO YOU, PLEASE MARK THE BOX THAT **MOST CLOSELY** DESCRIBES YOUR PRESENT -DAY SITUATION.

SECTION 1 - PAIN INTENSITY

- ☐ I have no neck pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

SECTION 2 - PERSONAL CARE

- ☐ I can look after myself normally without causing extra neck pain.
- ☐ I can look after myself normally, but it causes extra neck pain.
- ☐ It is painful to look after myself, and I am slow and careful
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self -care.
- ☐ I do not get dressed. I wash with difficulty and stay in bed.

SECTION 3 – LIFTING

- ☐ I can lift heavy weights without causing extra neck pain.
- ☐ I can lift heavy weights, but it gives me extra neck pain.
- ☐ Neck pain prevents me from lifting heavy weights off the floor but I can manage if items are conveniently positioned, ie. on a table.
- ☐ Neck pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all.

SECTION 4 – READING

- ☐ I can read as much as I want with no neck pain.
- ☐ I can read as much as I want with slight neck pain.
- ☐ I can read as much as I want with moderate neck pain.
- ☐ I can't read as much as I want because of moderate neck pain.
- ☐ I can't read as much as I want because of severe neck pain.
- ☐ I can't read at all.

SECTION 5 – HEADACHES

- ☐ I have no headaches at all.
- ☐ I have slight headaches that come infrequently.
- ☐ I have moderate headaches that come infrequently.
- ☐ I have moderate headaches that come frequently.
- ☐ I have severe headaches that come frequently.
- ☐ I have headaches almost all the time.

SECTION 6 – CONCENTRATION

- ☐ I can concentrate fully without difficulty.
- ☐ I can concentrate fully with slight difficulty.
- ☐ I have a fair degree of difficulty concentrating.
- ☐ I have a lot of difficulty concentrating.
- ☐ I have a great deal of difficulty concentrating.
- ☐ I can't concentrate at all.

SECTION 7 – WORK

- ☐ I can do as much work as I want.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I can't do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I can't do any work at all.

SECTION 8 – DRIVING

- ☐ I can drive my car without neck pain.
- ☐ I can drive my car with only slight neck pain.
- ☐ I can drive as long as I want with moderate neck pain.
- ☐ I can't drive as long as I want because of moderate neck pain.
- ☐ I can hardly drive at all because of severe neck pain.
- ☐ I can't drive my care at all because of neck pain.

SECTION 9 – SLEEPING

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed for less than 1 hour.
- ☐ My sleep is mildly disturbed for up to 1-2 hours.
- ☐ My sleep is moderately disturbed for up to 2-3 hours.
- ☐ My sleep is greatly disturbed for up to 3-5 hours.
- ☐ My sleep is completely disturbed for up to 5-7 hours.

SECTION 10 – RECREATION

- ☐ I am able to engage in all my recreational activities with no neck pain at all.
- ☐ I am able to engage in all my recreational activities with some neck pain.
- ☐ I am able to engage in most, but not all of my recreational activities because of pain in my neck.
- ☐ I am able to engage in a few of my recreational activities because of neck pain.
- ☐ I can hardly do recreational activities due to neck pain.
- ☐ I can't do any recreational activities due to neck pain.

PATIENT NAME _____ DATE _____

SCORE _____ [50]

HVERNON@CMCC.CA

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____ Date _____

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

	Headache			Neck			Low Back				
No pain	0	1	(2)	3	4	(5)	6	7	(8)	9	10	**worst possible pain**

---

1 – What is your pain RIGHT NOW?

No pain	0	1	2	3	4	5	6	7	8	9	10	**worst possible pain**

2 – What is your TYPICAL or AVERAGE pain?

No pain	0	1	2	3	4	5	6	7	8	9	10	**worst possible pain**

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain	0	1	2	3	4	5	6	7	8	9	10	**worst possible pain**

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain	0	1	2	3	4	5	6	7	8	9	10	**worst possible pain**

OTHER COMMENTS:

_____

_____

_____
Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

LOW BACK PAIN AND DISABILITY INDEX (REVISED OSWESTRY)

Patient Name: _____ Date: _____/_____/_____

Please read instructions carefully.
This questionnaire has been designed to give the doctor information as to how your low back pain has affected your ability to manage everyday life. Please read all statements in each section and mark the box which most closely describes your problem.

SECTION 1 - PAIN INTENSITY

- ☐ The pain comes and goes and is very mild.
- ☐ The pain is mild and does not vary much.
- ☐ The pain comes and goes and is moderate.
- ☐ The pain is moderate and does not vary much.
- ☐ The pain comes and goes and is very severe.
- ☐ The pain is severe and does not vary much.

SECTION 2 - PERSONAL CARE

- ☐ I do not have to change my way of washing or dressing to avoid pain.
- ☐ I do not normally change my way of washing or dressing even though it causes some pain.
- ☐ Washing and dressing increases the pain but I manage not to change my way of doing it.
- ☐ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- ☐ Because of the pain, I am unable to do some washing and dressing without help.
- ☐ Because of the pain, I am unable to do any washing or dressing without help.

SECTION 3 - LIFTING

- ☐ I can lift heavy objects without any extra pain.
- ☐ I can lift heavy objects, but it gives extra pain.
- ☐ Pain prevents me from lifting heavy objects off the floor.
- ☐ Pain prevents me from lifting heavy objects off the floor but I can manage if they are conveniently positioned on a table.
- ☐ Pain prevents me from lifting heavy objects but I can manage light to medium objects.
- ☐ I can only lift very light objects at the most.

SECTION 4 - WALKING

- ☐ I have no pain on walking.
- ☐ I have some pain but it does not increase with distance.
- ☐ I cannot walk more than one mile without increasing pain.
- ☐ I cannot walk more than 1/2 mile without increasing pain.
- ☐ I cannot walk more than 1/4 mile without increasing pain.
- ☐ I cannot walk at all without increasing pain.

SECTION 5 - SITTING

- ☐ I can sit in any chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than one hour.
- ☐ Pain prevents me from sitting more than half an hour.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ I avoid sitting because it increases pain.

SECTION 6 - STANDING

- ☐ I can stand as long as I want without pain.
- ☐ I have some pain on standing but it does not increase with time.
- ☐ I cannot stand for longer than one hour without increasing pain.
- ☐ I cannot stand for longer than 1/2 hour without increasing pain.
- ☐ I cannot stand longer than 10 minutes without increasing pain.
- ☐ I avoid standing because it increases the pain.

SECTION 7 - SLEEPING

- ☐ I get no pain in bed.
- ☐ I get pain in bed but it does not prevent me from sleeping well.
- ☐ Pain reduces my normal sleep by 1/4 each night.
- ☐ Pain reduces my normal sleep by 1/2 each night.
- ☐ Pain reduces my normal sleep by 3/4 each night.
- ☐ Pain prevents me from sleeping at all.

SECTION 8 - SOCIAL LIFE

- ☐ My social life is normal and gives me no pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ My social life is unaffected by pain apart form limiting more energetic interests.
- ☐ Pain has restricted my social life and I do not go out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of the pain.

SECTION 9 - DRIVING / RIDING IN CAR, ETC.

- ☐ I get no pain while traveling.
- ☐ I get some pain while traveling but none of my usual forms of travel make it any worse.
- ☐ I get extra pain while traveling but it does not compel me to seek alternate forms of travel.
- ☐ I get extra pain while traveling which compels me to seek alternate forms of travel.
- ☐ Pain restricts all forms of travel.
- ☐ Pain prevents all forms of travel except that done lying down.

SECTION 10 - CHANGING DEGREE OF PAIN

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates but overall is definitely getting better.
- ☐ My pain seems to be getting better but improvement is slow at present.
- ☐ My pain is neither getting better or worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

LOW BACK PAIN SCALE

Rate the severity of your **Low Back Pain** by indicating on the following scale.

Absence I----------I **Extreme**

Cumming Chiropractic Center

Authorizations and Release

Name: _____ Birthdate_____

Financial Agreement

Before the Doctor(s) of Cumming Chiropractic Center can provide you with their services, it is important that all financial arrangements be clearly understood. Our agreement for your health care is with you alone. Your insurance is not a part of this agreement. Policy benefits vary from company to company and from policy to policy within each company, you are advised that you may or may not be fully compensated under the provisions of your own insurance policy. Please note that the carrying of insurance by us is done as a courtesy to our patients. While insurance claims are being processed, your co-insurance/payment is due at the time of service.

However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

Patient's Signature_____ Date ____/____/_____ Witness_____

Medical Information Authorization to Release

I authorize the release of any medical information necessary to process my insurance claim(s) and also certify that all insurance information given to this clinic is correct and complete.

Patient's Signature_____ Date ____/____/_____ Witness_____

Request for Payment of Benefits to Provider of Care

I hereby authorize the _____Insurance Company/Insurance Administrator to pay by check, and for it to be mailed directly to *Cumming Chiropractic Center* the expense benefits allowable and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered. I have agreed to pay, in a current manner, any balance of said applicable charges. I agree that this office be given power of attorney to endorse/sign my name on any and all drafts for payment of my bill.

Patient's Signature_____ Date ____/____/_____ Witness_____

Acknowledgement of Receipt of Notice of Patient Privacy Practices

I have read or been provided with a Notice of Patient Privacy Practices that provides a description of healthcare information uses and disclosures, I understand that I have the following rights and privileges:

- The right to review the Notice prior to signing this consent
- The right to object to the use of my health information for directory purposes.
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations.

Patient's Signature_____ Date ____/____/_____ Witness_____

No Accident or Work Injury / No Secondary Insurance

I, the undersigned, state that I was not involved in any auto accident or personal injury caused by any other party. I further state that my diagnostic test or treatment is not the result of any injury while on the job or by any other person related to my employment.

I, also, state that I am not insured under any additional (secondary) health insurance policies.

Patient's Signature_____ Date ____/____/_____ Witness_____

Consent for Treatment of Minor (under age 18)

I hereby authorize the Doctors of *Cumming Chiropractic Center* and whomever they may designate as their assistant(s), to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as they deem necessary to my _____ (indicate relationship to child) _____(Child's name).

Guardian's Signature_____ Date ____/____/_____ Witness_____

Cumming Chiropractic Center

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk is most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Cumming Chiropractic Center have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ ____/____/____ ☐ *Witness Initials*

Patient or Authorized Person's Signature Date

REGARDING: X-rays/Imaging Studies

FEMALES ONLY → *please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

☐ The first day of my last menstrual cycle was on ____-____-____ Date

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ ____/____/____ ☐ *Witness Initials*

Patient or Authorized Person's Signature Date

Cumming Chiropractic Center **Medical Records Authorizations**

Name: _____ DOB_____

Medical Information Release Form (HIPAA Release Form)

I authorize to release my medical records to the person(s) or organization listed below:
I hereby request and authorize you, your employees and agents of Cumming Chiropractic Center to furnish to the person(s) listed below or anyone designated in writing by them, all copies of recrds and reports, including copies of x-rays and Photostat copies, abstracts or excerpts of all records and any other information they may request relating to any examination, treatment or opinion concerning any condition that I may have had in the past, now have, or may have in the future.

Name of person(s) medical record may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other _____

[ ] Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

MESSAGES

Please call my [ ] home [ ] work [ ] cell Number:_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

Patient's Signature_____ Date ____/____/_____

Witness_____ Date _____/_____/_____

Cumming Chiropractic Center

Photo Release

I give Cumming Chiropractic Center permission to photograph, film, or post details of my case (including one or more of the following: postural pictures, x-rays, adjustments, and or any comment or review that I may give) for the purpose of educating others about chiropractic care.

Signature: _____

Date: _____

I decline the right to photograph, film, or post details of my case (including one or more of the following: postural pictures, x-rays, adjustments, and or any comment or review that I may give) for the purpose of educating others about chiropractic care.

Signature: _____

Date: _____

CUMMING CHIROPRACTIC CENTER

299 Canton Road
Cumming, Georgia 30040

Phone: (770) 889-2208
Fax: (770) 889-0277

Dr. Jason Gregory, D.C.
www.drjasongregory.com

24 Hour Cancellation & "No Show" Fee Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Cumming Chiropractic Center reserves the right to charge a fee of $25 for all missed appointments, "no shows", and appointments without a compelling reason, are not cancelled with a 24-hour notice.

"No Show" fees will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next appointment. Multiple "no shows" in any 12-month period may result in termination from our practice.

Thank you for your understanding and cooperation as we strive to best serve the needs of all our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

Printed Name Date

Signature

Thank you for understanding.