PINEAPPLE
Chiropractic & Podiatry
PAIN. RELIEVED.

Acknowledgement

To set clear expectations, improve communications and help you get the results in the shortest amount of time, please read each statement and initial your initial understanding/agreement

_____ I Instruct the doctor to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health. I also understand that the doctor's care offered in this practice is based on the best available evidence and designed to reduce or correct abnormalities.

_____ I grant permission to be called/texted to confirm or reschedule appointments and to be sent occasional cards, letters, emails or health information as an extension of my care in this office.

_____ I acknowledge that any insurance I have is an agreement between the insurance company and me and that I am responsible for the payment of any covered or non-covered services that I receive.

_____ Any established patient who fails to show or cancels/reschedules an appointment and has not contacted the office with at least 12 hours notice will be considered a NO SHOW and may be charged for the full appointment fee.

_____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity, or cause of my health concern.

_____ _____

Print Name If the patient is minor, print guardian's name

_____ _____

Signature Date (MM/DD/YY)

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