

Crossroads Chiropractic – Appointment Etiquette

APPOINTMENTS

Please arrive on time for your appointments. The doctors do their best to stay on schedule and need your cooperation. Once a treatment plan is set, try to not alter the length of time between recommended visits until the doctor releases you to an as needed basis. If you are unable to keep an appointment for any reason, please call our office prior to the appointment to either reschedule or cancel so that we can accommodate another patient. Thank you for your cooperation.

LATE ARRIVALS

If you happen to arrive late for an appointment, your visit may be shortened and end at the normal allotted time to stay timely for the other patients whose appointments follow yours. Depending on how late you arrive, it is possible that you may have to reschedule.

RESCHEDULED, CANCELLED, and NO-SHOW APPOINTMENTS

Missed appointments represent a cost to us and to other patients that could have been seen from our waiting list in the time that was scheduled for you. This interferes with our clinic flow and creates scheduling issues for other patients.

If you cannot attend your appointment as scheduled, please call us 24 hours prior to the start of your appointment time by calling 320-252-3711. This allows us to call other patients that are on our waiting list. Since we turn away other patients to hold your appointment, any no-show/no-call appointments will result in a cancellation fee charged directly to the patient, not your insurance company.

The fee for a no-show visit will be \$50 that will be billed directly to you. This fee will be due prior to scheduling another visit.

Emergencies will be handled on a case-by-case basis. If you have an emergency where you are unable to call us, please let us know the circumstance and we will gladly waive the fee.

I have read and understand the terms of this form. I also understand that the no-show fees have nothing to do with my co-pay or deductible and cannot be billed to my insurance company. Furthermore, I understand that if I fail to adhere to the above policies, I will be billed/charged by Crossroads Chiropractic Clinic for any fees that are incurred.

Patient Name

Signature

Date

Staff initials: _____ Date: _____