WESTSIDE CHIROPRACTIC & ASSOCIATES

1430 West 7TH Avenue, Vancouver, BC, V6H 1C1 PHONE: 604-738-2503 FAX: 604-738-2506

DR. AARON K. HOY D. C.
DR. ENRIQUE A. DOMINGO D. C.
MARNIE MYALL R. M. T
KIRSTEN SPOULER R. M. T.

It is our intention to help you achieve your goal of obtaining the best care possible for your health.

OFFICE POLICY

1. You will be made fully aware of what is involved in your chiropractic or massage treatment.
2. Your doctor will make out a treatment plan specific to your needs.
3. The treatment outlined and the fees quoted will be adhered to unless otherwise stated by the office manager.
4. We need a 24 hour advanced notice if you need to cancel or reschedule your appointment so this time can be allotted to patients on our waiting list.
5. There will be a charge for a missed appointment ($20-45). Missed appointment charges will be based on the practitioner's fee for the time that had been reserved for your visit.

AGREEMENT

1. I agree to make full payment at the time services are rendered unless arrangements have been made prior to my treatment.
2. I agree to notify the office if I cannot keep an appointment.
3. I hereby assign my benefits, payable from claims submitted electronically to my practitioner and authorize payment directly to him/her. This authorization shall continue in effect until the undersigned revokes the same.
4. I agree to be responsible for my decision to follow or not to follow the recommended treatment given by my doctor.

_____
Patient Signature (parent or guardian if applicable)

_____
Practitioner