THE NIELSEN CLINIC

1755 Prospector Ave Suite 100
Park City, UT 84060

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Disclosure of Office Fees and Policies

We would first like to take a moment to welcome you to our chiropractic office and let you know that you are very important. We are determined to let you know what condition(s) you have through thorough examination and diagnostic testing. You will be receiving the best available care. Due to the nature of care in this office, we ask that you read, understand, and sign the following disclosure of fees and payment policies.

I know that I am responsible for **payment in full at the time of service**. I understand that the **initial examination fee is $180**. Treatment prices are based upon the scheduled time as well as any additional time spent with the doctor(s). I know that each **10-minute increment is $40**. Dependent upon the specific recommendations of the doctor, other fees for services apply. Should I desire, a complete list is available at the front desk for me to see at any time. All fees are subject to change without notice.

I know that if I am **late arriving for an appointment, the doctor will see me for the remainder of my scheduled visit**. However, the **full price** of the scheduled time will be charged.

I acknowledge that the policy of The Nielsen Clinic is to schedule only one person to a specific time slot. This allows the doctor to devote undivided attention to each individual. By honoring my time as well as the doctor's, we can obtain the maximum benefit during my treatment.

In the event of a **no-show** for any reason, I will be **charged for the full appointment time**. By signing this form, I authorize The Nielsen Clinic to fulfill this transaction.

If a 24-hour cancellation notice is given, I will not be charged for the appointment.

Any nutritional supplements that are recommended to me, I will pay for at the visit.

I fully understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that The Nielsen Clinic upon request will prepare an invoice stating services rendered for me to submit to preferred insurance company. However, I clearly understand that I am ultimately responsible for payment in full at the time of service. I agree that if any expense is incurred in the collection of any monies due on my account, this amount will also become my responsibility.

I have read, understand, and agree to the above terms.

Signature_____Date_____