THE NIELSEN CLINIC

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WE BELIEVE THAT EVERY PERSON HAS THE RIGHT TO EXPECT THE VERY BEST PROFESSIONAL CARE WE CAN PROVIDE.

In turn, we expect cooperation in establishing a definite financial arrangement. Accordingly, we have established the following policies.

1. The INITIAL OFFICE VISIT IS PAYMENT IN FULL. All subsequent visits are also payment at time of service.
2. Patients involved in LITIGATION (law suits) are, as others, responsible for their services here at the clinic at the time of service.
3. Unless a patient is under CURRENT CARE in this office (within the past six months) an examination may be necessary to reinstate proper treatment. Each new injury may require an examination due to the possibility of structural changes.
4. PATIENTS ARE SEEN IN THE ORDER SCHEDULED, NOT BY WAITING ROOM SENIORITY. However, should a patient be late, others waiting will be seen in their order of appointment.
5. We reserve the right to BILL FOR MISSED APPOINTMENTS since time has been reserved for your health care. A 24-hour notice is required so that time can be used to schedule someone else.
6. For health considerations and due to the close interpersonal nature of the work, your PERSONAL CLEANLINESS IS REQUIRED for a comfortable environment.
7. SMOKING IS PROHIBITED because of its harmful effect on the other patients as well as the staff.
8. I grant this office permission to seek all legal means necessary to collect delinquent monies that I owe. In addition to my outstanding balance, I WILL REIMBURESE FOR LEGAL AND COLLECTOR FEES included in the process.

Patient Name_____Cell phone_____
Street/PO Box #_____Work Phone_____
City/State & Zip Code_____
Age_____Birthdate_____Email:_____
Occupation_____Employer_____
Name of spouse (husband/wife)_____Phone_____
Spouse's occupation_____Employer_____
By whom were you referred?_____
In the event of an emergency, whom should we notify?_____Phone_____
Friend or relative not living with you_____Phone_____

MY SIGNATURE IS AN ACKNOWLEDGEMENT THAT I HAVE READ THE POLICIES ABOVE AND AGREE TO ABIDE BY THE SAME.

PATIENT SIGNATURE_____Date_____
The patient is a minor. Permission is hereby given by me to the doctors of this office and whomever they designate to treat the patient. I am his/her legal guardian.