



THE NIELSEN CLINIC

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 agreement. Accordingly, we have established the following policies:

1. The INITIAL OFFICE VISIT IS PAYMENT IN FULL. All subsequent visits are also payment at the 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 change.
4. PATIENTS ARE SEEN IN THE ORDER SCHEDULED, NOT BY WAITING ROOM SENIORITY. However, should a patient be late, others waiting will be seen.
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 another patient.
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 other patients and 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 REIMBURSE FOR LEGAL AND COLLECTOR FEES included in the process.

Patient Name _____ Cell phone _____
 Street/PO Box # _____
 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, whome 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 _____

If 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.

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