Family Chiropractic & Massage Therapy
advance

Bernadette Morin
Robert Cory Del Medico
Registered Massage Therapists

Massage and Acupuncture Agreement

Welcome to our office! By coming in today you have made an important commitment to your health. I hope you enjoy your experience with massage and/or acupuncture as we work together to help you attain your full health potential. Please read the following to acquaint yourself with a few of our policies. The purpose of this agreement is to allow us to serve you more completely and to get the best results in the shortest amount of time. It is our experience that those patients who adhere to the following agreement get the best results.

Fees

Payment is required upon receipt of service. Payment methods include cash or cheque.

Treatment Length	30 minutes	45 minutes	60 minutes
Adults	$55.00	$75.00	$95.00
Children 12 and under and Seniors	$45.00	$65.00	$80.00

Extended Health Care

Most extended health care programs will pay part of massage and or acupuncture fees. We will be happy to provide the necessary receipts to facilitate your claim. (Please note that the patient is responsible for submitting the claim to their insurance company). This is an agreement between the patient and the insurance company, not between your massage therapist and insurance company.

Motor Vehicle Accident

If your care is the result of a motor vehicle accident, you are covered for massage care through your automobile insurance policy. Be aware that your automobile insurance will not cover your treatment until you have exhausted any other extended health benefits you may have. Our office will submit all necessary paperwork to your insurance company on your behalf including invoices for treatment but we are NOT reimbursed by them. You are responsible for paying the fees associated with your care and will then receive compensation from your insurance company directly.

Workplace Safety and Insurance Board (WSIB)

This office asks that the patient provide us with a post-dated cheque for $270 to cover care until we receive approval from WSIB. Once approved, the cheque will be returned to you. If not approved, the $270 will be used to cover your care to date. Should you choose to discontinue care with us, the unused portion of the cheque will be immediately refunded.

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Emergencies

Your discomfort is our immediate concern. In the case of an emergency, please call the office and we will arrange for you to be seen at the first possible opportunity.

Appointment times

We strive to run on time. If your condition changes or you have a new concern that you need to discuss, please call the office so that we may book the appropriate amount of time for you. If you are 10 minutes late or more for your appointment time, you will be asked to reschedule out of respect for the other patients who have arrived on time.

We appreciate 24 hours notice of a cancellation. Patients will be billed for appointments missed without notification.

Patient Co-operation

We will set up a specific course of treatment for you. A certain number of treatments in a set amount of time are required for us to get the results we desire. Therefore, if you need to change an appointment, it is necessary for you to reschedule to make up that appointment within the week. This will enable you to maintain your treatment schedule. You must realize that a missed appointment may increase the number of visits required for you to reach optimum health.

An informed consent will be presented to you to be signed. Following this, the appropriate treatment will be administered as explained previously.

No smoking, alcohol, or illicit substance use is allowed on the premises. Treatment will be refused if the patient is, or is suspected to be, under the influence of any of the aforementioned.

Your Health and Happiness

We are here to serve you, our patient. Please speak to the Massage Therapist or office manager about any upsetting matters. We see your comments as helping us to help you and others. Please feel free to discuss any aspect of your care with us at any time.

I have read and understood the above patient policy and accept this policy as stated.

_____	_____
Please print name	Signature
_____	_____
Date	Guardian, if patient is under 16 years of age