INFORMED CONSENT FOR TREATMENT – BENEFITS & RISKS as of 01/01/2026

I understand that I am the decision maker for my health care. Part of Hatch Chiropractic & Wellness' role is to provide me with information to assist me in making informed choices. The purpose of the Informed Consent to Treatment is for my understanding and agreement regarding the care recommended, the benefits and risks associated with the care, alternatives and potential effects on my health if I choose not to receive the care.

Initials_____ ***I confirm that I have read and fully understand the Informed Consent to Treatment. I understand the risks and benefits of the procedures and have had an opportunity to ask questions.***

X-RAY RELEASE as of 01/01/2026

Initials_____ ***I certify that, to the best of my knowledge, I am not pregnant, and the clinical staff has my permission to perform ordered x-rays. I have been advised that x-rays may be harmful to an unborn child.***

If applicable, date of last menstrual cycle: _____

HIPAA INFORMATION & CONSENT as of 01/01/2026

Hatch Chiropractic & Wellness complies with the Health Insurance Portability and Accountability Act (HIPAA) and provides protection of your Personal Health Information (PHI) while providing professional service and care. You have the right to request HIPAA documentation at any time.

Initials_____ ***I confirm that I have been informed of and understand the HIPAA Information & Consent notice, and the full document has been made available to me. Any questions that I may have about this statement have been answered and I fully understand this agreement.***

DECLARATION OF SERVICES as of 01/01/2026

Self-Pay Patients: One therapy, as recommended by your doctor, is included with your adjustment. Therapies include electrical stimulation, ultrasound or cupping. If you elect to receive more than one therapy, there will be an additional charge for that service. There is an **additional fee** for extended appointment times with the doctor for either soft tissue work or dry needling.

Insurance Patients: If you receive electrical stimulation, ultrasound or cupping per your doctor's recommendation, there is an **additional fee** for that therapy. If you elect to receive more than one therapy, there will be an additional charge for that service. *Insurance does not cover therapies, Graston, K-Laser, Shockwave or Decompression.* There is an **additional fee** for extended appointment times with the doctor for either soft tissue work or dry needling – insurance does not cover this fee.

K-Laser - $75 / Shockwave - $75 / Decompression - $75 / Graston $15-$30 / Cash Rate X-Rays $50

Initials _____ ***I confirm that I have been informed of and understand the Declaration of Services notice. Any questions that I may about this statement have been answered and I fully understand and agree to comply with the policies as outlined above.***

APPOINTMENT CANCELLATION & NO-SHOW POLICY as of 01/01/2026

To ALL Patients: In the event you need to reschedule your appointment, we require you to give our office **24-hour notice.** We understand that there are times when you must miss an appointment due to emergencies, however you must call our office to inform us of the circumstances.

If you miss an appointment without contacting our office within 24 hours of your scheduled time, it will be considered a ***missed appointment*** and **a fee of $60 will be charged to you. The fee for a missed acupuncture appointment is $80, missed massage appointment fee is $99.** *This fee cannot be billed to your insurance company and will be YOUR direct responsibility.*

Additionally, if you arrive more than 15 minutes past your appointment time, that appointment must be rescheduled. This will be considered a ***missed appointment***, and the **appropriate fee will be charged to you.**

A valid credit card is required to be on file. In the event you fail to call within 24 hours or do not show up for your appointment, your credit card will be charged accordingly.

Initials_____ ***I agree that I have been informed of the Appointment Cancellation & No-Show Policy notice. Any questions that I may have about this statement have been answered and I fully understand and agree to comply with the policies as outlined above.***

_____	_____	_____
Patient/Guardian Signature	***Patient's Printed Name***	***Today's Date***