Whom may we thank for referring you to this office → _____?

APPLICATION FOR CARE AT Hanson Chiropractic Center

Today's Date: _____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: ____-____-____ Age: _____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____ Home Phone: _____

Mobile Phone: _____ Work Phone: _____

Marital Status: ☐ Single ☐ Married Do you have Insurance: ☐ Yes ☐ No

Social Security #: _____ Driver's License #: _____

Employer: _____ Occupation: _____

Spouse's Name _____ Spouse's Employer _____

Number of children and Ages: _____

Name & Number of Emergency Contact: _____ _____ Relationship: _____

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office: Primarily: _____

Secondarily: _____ Third: _____ Fourth: _____

On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate you're above complaints by ***circling the number*:**

Primary or chief complaint is : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Second complaints is : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Third complaint: : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Fourth complaint: : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When did the problem(s) begin? _____ When is the problem at its worst? ☐ AM ☐ PM ☐ mid-day ☐ late PM

How long does it last? ☐ It is constant **OR** ☐ I experience it on and off during the day **OR** ☐ It comes and goes throughout the week **How did the injury happen?** _____

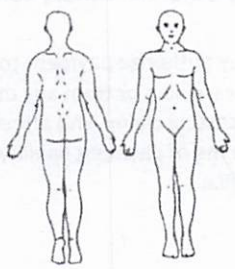
Condition(s) ever been treated by anyone in the past? ☐No ☐ Yes If **yes,** when: _____ by whom? _____

How long were you under care: _____ what were the results? _____

Name of Previous Chiropractor: _____ ☐ N/A

*__PLEASE MARK__ the areas on the Diagram with the following **letters** to describe your symptoms:

R = Radiating B = Burning D = Dull A = Aching N = NumbnessS = Sharp/ Stabbing T= Tingling



What relieves your symptoms? _____

What makes them feel worse? _____

LIST RESTRICTED ACTIVITY :	CURRENT ACTIVITY LEVEL	USUAL ACTIVITY LEVEL
_____ :	_____	_____
_____ :	_____	_____
_____ :	_____	_____

Is your problem the result of ANY type of accident? ☐ Yes, ☐ No

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

_____

_____

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? ☐ No ☐ Yes If yes how many times? _____ When was the last episode? _____ How did the injury happen? _____

Other forms of treatment tried: ☐ No ☐ Yes If yes, please state what type of treatment: _____, and who provided it: _____ how long ago? _____What were the results. ☐ Favorable ☐ Unfavorable→ please explain.

_____ _____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

_____

_____

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the ***Past***, **C** for ***currently*** have and **N** for ***Never have had***:

___ Broken Bone ___Dislocations ___ Tumors ___Rheumatoid Arthritis ___ Fracture ___Disability ___Cancer ___ Heart Attack ___Osteoarthritis ___ Diabetes ___Cerebral vascular ___ other serious conditions:

PLEASE identify ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES →			
SURGERIES →			
CHILDHOOD DISEASES→			
ADULT DISEASES →			

SOCIAL HISTORY

1.Smoking: ☐cigars ☐ pipe ☐ cigarettes how often? ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

2. Alcoholic Beverage: consumption occurs ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

3. Recreational Drug use: ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

4. Hobbies -Recreational Activities- Exercise Regime: How does your present problem affect the following, See pg.2 Activities of Daily Life

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s)? ☐ No ☐ Yes

If yes whom: ☐ grandmother ☐ grandfather ☐ mother ☐ father ☐ sister's ☐ brother's ☐ son(s) ☐ daughter(s)

Have they ever been treated for their condition? ☐ No ☐ Yes ☐ I don't know

2. **Any** other hereditary conditions the doctor should be aware of. ☐ No ☐Yes: _____

I hereby authorize payment to be made directly to Hanson Chiropractic Center for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to [CLINIC NAME] for any and all services I receive at this office.

INITIAL NERVE SYSTEM PROFILE

When was your most recent auto accident? _____

What speed was the collision? _____

Type of impact: Front Impact / Side Impact / Rear Impact

Was treatment received? Please describe _____

When was your most recent strain / stress at work? _____

Please describe the manner of the injury _____

Was treatment received? Please describe _____

Does your job require you remain in long term stressful postures? _____

(I.e. all day seating, repeated lifting, long term computer use)

Spinal traumas in the past? _____

Collision, quick burst, or repetitive motion sports: football, wrestling, basketball, baseball, soccer, tennis, golf, track and field_____

Trauma as a child! I.e. fall on your head, impact to your head, concussion, fall onto your back or tailbone, biking accident_____

Work around the house – lifting, bending, woke up with stiff neck, "back went out"

INITIAL NERVE SYSTEM PROFILE

Have you tested with high triglycerides or high cholesterol? (Y / N) Values? _____

Have you tested with high blood pressure? (Y / N)

Are you diabetic? Have you been diagnosed as pre-diabetic or with metabolic syndrome? (Y / N)

How many days per week do you skip on meal? (0) (1) (2) (3) (4+)

How many servings of fruit do you have on a given day? (0-1) (2-3) (4-5)

How many servings of vegetables do you have on a given day? (0-1) (2-3) (4-5)

Do you regularly drink 1 (or more per day) of any of the following? (Circle all that apply)

Diet Soda Coffee Juice Milk Soda Alcohol

Please list any supplements you take regularly.

_____

_____

Activities of Daily Life

Daily Activities: Effects of Current conditions On Performance

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

Bending	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Concentrating	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Computer Work	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Gardening	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Playing Sports	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Recreation Act.	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Shoveling	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Sleeping	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Watching TV	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Carrying	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Dancing	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Lifting	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Pushing	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Rolling Over	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Standing	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Working	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Climbing	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Doing Chores	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Reading	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Running	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting to Standing	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform

Please mark P for in the Past, C for Currently have and N for Never

___ Headache	___ Pregnant (Now)	___ Dizziness	___ Prostate Problems	___ Ulcers
___ Neck Pain	___ Frequent Colds/Flu	___ Loss of Balance	___ Impotence/Sexual Dysfun.	___ Heartburn
___ Jaw Pain, TMJ	___ Convulsions/Epilepsy	___ Fainting	___ Digestive Problems	___ Heart Problem
___ Shoulder Pain	___ Tremors	___ Double Vision	___ Colon Trouble	___ High Blood Pressure
___ Upper Back Pain	___ Chest Pain	___ Blurred Vision	___ Diarrhea/Constipation	___ Low Blood Pressure
___ Mid Back Pain	___ Pain w/Cough/Sneeze	___ Ringing in Ears	___ Menopausal Problems	___ Asthma
___ Low Back Pain	___ Foot or Knee Problems	___ Hearing Loss	___ Menstrual Problem	___ Difficulty Breathing
___ Hip Pain	___ Sinus/Drainage Problem	___ Depression	___ PMS	___ Lung Problems
___ Back Curvature	___ Swollen/Painful Joints	___ Irritable	___ Bed Wetting	___ Kidney Trouble
___ Scoliosis	___ Skin Problems	___ Mood Changes	___ Learning Disability	___ Gall Bladder Trouble
___ Numb/Tingling arms, hands, fingers		___ ADD/ADHD	___ Eating Disorder	___ Liver Trouble
___ Numb/Tingling legs, feet, toes		___ Allergies	___ Trouble Sleeping	___ Hepatitis (A,B,C)

List Prescription & Non-Prescription drugs you take:

_____

_____

_____

_____

Print Name: _____ Date: _____/_____/_____

Patient or Authorized Person's Signature: _____

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at the Hanson Chiropractic Center have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ ____/____/____

Patient or Authorized person's Signature Date

REGARDING: X-rays/Imaging Studies

FEMALES ONLY → *please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

☐ The first day of my last menstrual cycle was on ____-____-____ Date

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ ____/____/____

Patient or Authorized person's Signature Date

OUR OFFICE POLICIES

ADMINISTRATIVE- NOTICE OF- OFFICE POLICIES

As a potential new patient, we feel it is important that you understand our office policies regarding, how patients of this practice are cared for, and the various methods we offer to facilitate payment for that care. **Please read each policy carefully so there is no misunderstanding as to what you can expect as a patient of this practice, and what we expect in return.**

☐ **YOUR CARE** - When a patient seeks chiropractic health care and we agree to provide that care, it is essential for the patient and the doctor to be working toward the same objective. Chiropractic care at Hanson Chiropractic Center is rendered primarily to minimize and reduce subluxations. The doctor uses Petabon Spinal Correction and activator adjustments through a myriad of techniques to accomplish this goal. It is important that you understand both the objective and the method(s) so there is no confusion or disappointment. Tremendous progress has been made in the rehabilitating and correction of spinal problems. Where in the past, chronic spinal structural problems could not be reversed or corrected, today they can. **Your doctor will outline a course of treatment that will take you beyond simple pain relief, through two distinct phases of care to make a structural correction to your spine that will enable your central nervous system to function optimally, thereby improving your overall health.**

☐ **FIRST DAY GOALS**- Prior to receiving chiropractic care at this office, a health history and examination will be completed. Imaging studies as well as any other necessary diagnostics may also be ordered, to confirm the true nature of your condition and exact location of subluxations. The results of these procedures will aid in assessing your presenting problem, your overall health and, in particular, the condition of your spine. They will also assist the doctor in determining the type and amount of care you will need. All relevant findings will be reported to you along with care plan recommendations so that you can make the best possible decision regarding your health care needs. Our gold standard for care is to ensure the reduction of subluxations while teaching patients what they need to do to maintain their health for a lifetime, in additional to being adjusted.

☐ **PATIENT'S REPORT OF FINDINGS** - To enhance your understanding of the chiropractic approach that will be used to manage your health, immediately following your first adjustment, you will be scheduled for a 'Doctors Report of Findings'. **The information you receive at this appointment will be both informative and clinically relevant to your case, therefore attendance is required for individuals who wish to become new patients of this practice. Because the results of your x-rays and all examinations as well as the doctors' recommendations for care, will be discussed at that time, we strongly urge new patients to invite their spouse or significant other to attend.** We know from experience that when a patient's family understands the goals and objectives of chiropractic care and how restoring and maintaining good health can affect their lives as well, they become infinitely supportive and helpful in making important decisions concerning treatment options.

☐ **PATIENT PRIVACY** -It is important to understand that any conversations you have with the doctor could potentially be overheard by other patients. In order to maintain patient privacy, it is the policy of this practice to refrain from discussing any confidential matters with patients during treating hours while patients are being adjusted. If you have a confidential matter you wish to discuss, please let us know and we will schedule time for you to speak to the doctor in a private consultation room. **These consultations must be scheduled in advance.**

☐ **INSURANCE COVERAGE**- All services that are billable to insurance will be submitted, as outlined according to the care plan recommended by the doctor. Not all chiropractic services are billable/covered by insurance companies. Any insurance coverage will be verified within 48 hours of the patient's first appointment. Payments for all charges are due in full until the verification is complete. **All verifications are an estimate of coverage based on the information provided by the policy and not a guarantee of payment. Any balance remaining after payment is the responsibility of the patient.**

☐ **PAYMENTS**- Based on the care prescribed by the doctor, payment options will be presented on your 3rd visit during the Patient's Report of Findings. We accept Cash, Check, VISA, Mastercard, AMEX or Discover. Additionally, please let us know if you have a Health Savings Account or Health Reimbursement Account. Some payment arrangements do require that we maintain a valid credit card on file through our secure online processing service. **Non-refundable items include:** Supplements, Headweights, Traction, Wobble Cushion, and opened packages of Spinal Moldings or

OUR OFFICE POLICIES

Wedges. If you choose to discontinue care at any time, payment/refund for services rendered will be collected upon close of account. Account will not be closed until all outstanding insurance claims are processed by the patient's insurance company. If patient balance remains unpaid after two notices of payment due are sent, a fee of $10 will be charged for certified mail and collection services acquired to seek payment. Hanson Chiropractic Center utilizes Action Collections to acquire unpaid balances after 3 months of non-payment.

Over time it is our goal that you gain a greater understanding as to the purpose of chiropractic. Patients who are accepted for care have a unique opportunity to observe firsthand the positive results and benefits derived from being under chiropractic care. This knowledge and awareness reaps a positive environment that promotes healing and encourages families to maintain good health. We want your experience with us to be an exceptional one, so help us to help you. Together, we can make affirmative changes in your life and the lives of those you care about.

If you have any questions regarding these policies, before submitting your ***Application for Care***, please ask and we will be happy to discuss them with you further. We want you to make an informed decision about your applying for care at this office. Therefore, it is important for you to understand these policies, how Dr. Ryan practices chiropractic, and how we can help you receive the best care to achieve your goals for health.

Note: Patient and Office retains a copy of this policy agreement.

I hereby acknowledge receiving a copy of the practices 'Office Policies' a two page document. I assign to Hanson Chiropractic Center the rights under all insurance and benefit plan documents, and authorize direct payment to each healthcare provider of all insurance and plan benefits payments for services provided to me (or the patient) by this provider. By paying my provider directly, my insurance company or employer is fulfilling its obligation to me (or the patient) under the health insurance policy, or the employer is fulfilling its obligations as required by law. I also agree that I (or the patient) am financially responsible for charges not paid according to this assignment.

My signature acknowledges that I have received a copy of these policies and understand this 'Notice'. I further acknowledge that any concerns regarding these 'Policies 'as well as all my questions have been answered by a qualified member of the staff to my complete satisfaction.

_____ _____

Patient's Name DOB

_____ _____

Patient signature Date

Hanson Chiropractic Center's NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy,** we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled **'HIPAA'** on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes- discussion with other health care providers involved in your care
2. Inadvertent disclosures- open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes- to process a claim or aid in investigation
5. Emergency- in the event of a medical emergency we may notify a family member
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons –discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders **-we may call your home and leave messages** regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice
3. To request mailings to an address different than residence
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Dr Ryan at (405) 341-0494. If he is unavailable, you may make an appointment with our receptionist to see him within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

Hanson Chiropractic's NOTICE REGARDING YOUR RIGHT TO PRIVACY continued....

I have received a copy of Hanson Chiropractic's Patient Privacy Notice. I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this 'Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____ _____

Patient's Name DOB

_____ _____

Patient signature Date

_____ _____

Witness Date

Please list below anyone whom you give legal access to your Medical Records/ Accounting information:

Name	Phone #	Relationship to Patient
Name	Phone #	Relationship to Patient

Hanson Chiropractic Center

1717 S. Boulevard, Edmond, OK 73013

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care & we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has one primary goal. It is important that each patient understand both the objective & the method that will be used to attain it. This will prevent any confusion or disappointment:

- **Problem: Vertebral Subluxation**: A misalignment of one or more of the 24 vertebra in the spinal column, which causes alteration of nerve function & interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

- **Solution: Adjustment:** An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments on the spine.

- **Goal: Health**: A state of optimal physical, mental & social well-being, not merely the absence of disease or infirmity.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the service of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others.

OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read & fully understand the above statements.
(Print Name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.
I therefore accept chiropractic care on this basis.

Signature	DOB	Date

Office Appointment Cancellation Policy

At Hanson Chiropractic, we understand that unexpected circumstances may arise. However, in order to provide the best service to all of our patients, we ask that you please follow our appointment cancellation policy:

1. **Cancellation and No-Show Policy**:
    - If you need to cancel or reschedule your appointment, we require a minimum of **24 hours' notice.**
    - **Cancellations or no-shows with less than 24 hours' notice** may result in a **cancellation/no-show fee.**
2. **Late Arrivals**:
    - Arriving late may result in a longer wait time. If you arrive **more than 15 minutes late**, we may need to reschedule your appointment.
3. **Emergency Cancellations**:
    - We understand that emergencies happen. If you need to cancel your appointment due to an emergency, please contact us as soon as possible.
4. **Fee Structure**:
    - **Cancellation Fee/No-Show Fee**: $30
5. **How to Cancel**:
    - You can cancel or reschedule your appointment by calling our office at 405-341-0494 or emailing us at hansonccedmond@gmail.com.

We appreciate your understanding and cooperation in helping us maintain a smooth and efficient scheduling system for everyone.

Print Name:_____

Signature:_____ Date:_____