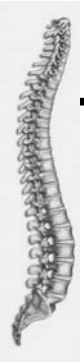


Kenn E. Iverson, D.C.

CHIROPRACTIC ARTS CLINIC
312 2nd Ave SW
Jamestown, ND 58401
Ph: 701.252.2424
Fax: 701.252.3205

OFFICE POLICY

We are committed to providing you the best care available. We value you as a patient and we believe that a clear definition of our office policies allows both you the patient, and the doctor, to concentrate on the big issue – REGAINING AND MAINTAINING YOUR HEALTH.

NEW PATIENTS. If we are unable to confirm insurance coverage at the time of your appointment, payment for the entire visit will be due at the time of service.

APPOINTMENTS. We understand that sometimes circumstances arise that prevent patients from keeping appointments. It happens to the best of us! If you find it impossible to keep an appointment, please give us a call in advance at 252-2424, or e-mail us at chiroinfo@csicable.net within a few hours of your appointment. With this prior notice, we can reschedule your appointment and let another patient have the appointment time originally reserved for you.

We are now charging $25 to those who frequently regret to inform us of missing their appointment time. We do allow mistakes as we all make them time to time. Please be aware of our no show fee.

INSURANCE. We will bill your primary and secondary insurance companies for the treatment you receive. It is your responsibility to contact your insurance company to verify coverage. You are responsible to update your insurance information if it changes. If your insurance company denies payment to cover your care by our office for any reason (including, but not limited to: non-covered charges, out-of-network provider, no medical necessity, no referral, not valid coverage date), then you will be held financially responsible for all fees for medical care you received that your insurance has denied payment on. You may wish to pursue the claim with your insurance company personally and we are happy to provide you with appropriate documentation.

PAYMENT. We accept payment by cash, check, MasterCard or VISA.

TERMS OF ACCEPTANCE. When a patient seeks Chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

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

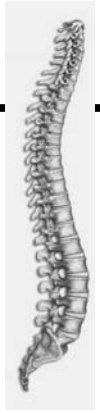
Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

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

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

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 services 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.



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OFFICE POLICY

This form will be retained in your medical record.

This notice is effective as of _____/_____/_____

By way of my signature, I acknowledge that I have received a copy of and read the office policy and I agree to the terms and conditions.

_____	_____
Printed name of Patient	Date of Birth
_____	_____
Patient or legally authorized individual signature	Date Time
_____	_____
Printed name of authorized individual	Relationship (parent, POA, caretaker, etc.)
_____	_____
Authorized Clinic Employee signature	Date