



DONALD K SHIFLET, DC
CHIROPRACTIC PHYSICIAN

MESSAGE THERAPY POLICY AGREEMENT & ACKNOWLEDGEMENT

Print Name _____

Phone Number (_____) _____ Date of Birth ____/____/____

We ask for a credit card to guarantee your massage appointments. You will not be charged now; payment will be collected in office at the time of your scheduled appointment. Providing a credit card to guarantee your massage appointment is optional. If you opt not to provide a credit card and your appointment results in a late cancellation or no show, we will be unable to reschedule you until the fee is paid.

CREDIT CARD INFORMATION	
Cardholder Name (as shown on card):	
Credit Card Number:	
Expiration Date (mm/yy):	CCV/CVV Number:
Cardholder ZIP Code (from credit card billing address):	

YOU MAY CANCEL THIS AUTHORIZATION AT ANY TIME BY CONTACTING US. THIS AUTHORIZATION REMAINS IN EFFECT UNTIL CANCELLED.

Cancellation Policy Cancellation is free up to **24 hours** in advance. Appointments are in high demand and your advanced notice will allow another patient access to that appointment time. *After 24 hours a \$25.00 late cancellation fee will be charged. New and/or first appointments that result in a no show or late cancellation will be charged 100% of the scheduled fee.*

Late Cancellations/No-Shows A cancellation is considered late when the appointment is cancelled less than **24 hours** before the appointed time. A no-show is when a patient misses an appointment without cancelling. In either case, we will charge the patient a missed appointment fee as outlined above.

How to Cancel Your Appointment If you need to cancel or reschedule your appointment time, please call us at (520) 877-2666. If necessary, you may leave a voicemail message. We will return your call as soon as possible. Cancellations by email *can not* be accepted.

I, _____, authorize **Back Benders Inc dba The Back Alley Chiropractic & Massage** to charge my credit card above for any agreed upon services rendered. I understand that my information will be saved to file for future transactions on my account.

Patient Signature

Date