Today's Date: ____________________________

Stately Chiropractic Group

275 Victoria Street • Suite 2C • Costa Mesa • CA • 92627
Office: 949-645-6325 Fax: 949-645-6322
www.statelychiro.com

Patient Information for Medical Records

Last Name: ____________________ First Name: __________________ MI: _____ Birth date: _________

❒ M ❒ F Referred by: ____________________________ Relation: ____________________________

Home Address: ____ Home Phone ____________________

City: _________________________ State: ______ Zip: __________ Cell Phone: ____________________

Email Address: ____

Address: ____

City: _________________________ State: ______ Zip: __________

Please put a check mark next to the best phone number or email that our office can contact you for appointment notifications, treatment status, test results, or billing questions.

Due to HIPPA Regulations, if our office is leaving a message, please check appropriate item:
_____Ok to Leave a Detailed Message _____Leave Return # Only

Employer: ____ Work Phone: ___________________

Address: ____

City: _________________________ State: ______ Zip: __________

Emergency Contact Name: ____________________________________ Home Phone: ___________________

Address: ____ Work Phone: ___________________

City: _________________________ State: ______ Zip: __________ Email: ________________________

Consent to treatment of minor: RE: ______________________(name), a minor. I (we), being the parent(s) or guardian(s), entitled to the care, custody and control of the aforesaid minor, do hereby authorize and direct you to render such treatment to said minor as in your judgment is advisable. It is understood that the above minor may occasionally appear at your office for examination and/or treatment, unaccompanied by an adult, because of my (our) absence or unavailability. This consent will be in effect until terminated by written notice.

Signature: ____ Date: ________________________

Please provide us with a copy of your insurance card and additional information including secondary carrier.

Date________________ | **HEALTH QUESTIONNAIRE** | **Stately Chiropractic Group**

Name____________________
Purpose of your visit: ____
Date of accident / illness: _____/_____/_____ Time: __________am/pm Location: ______________________________
How did it occur? ☐ Auto Collision, ☐ On-the –Job, ☐ Other: ____
Please describe the circumstances: ____
____
Have you lost time from work? ☐ Yes ☐ No
Have you seen any other doctors for this condition? ☐ Yes ☐ No If yes, who and when: __________________________
Have you had any other significant accidents or injuries? ☐ Yes ☐ No
Please describe the circumstances: ____
List Medications or supplements: ____
Previous broken bones: ____
Previous Hospitalizations or Surgeries ____
____
Have you or any immediate family members had any major disease? Please explain: ____________________________
____

On the following scale, please indicate the severity of your complaint:

0	1	2	3	4	5	6	7	8	9	10

No Pain Severe Pain

Please indicate: O **for Present Complaints**
Please indicate: ☐ **for Past Complaints**

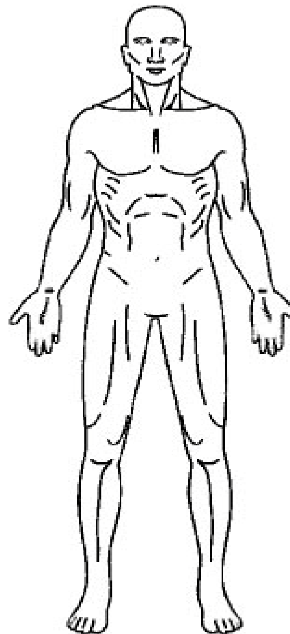
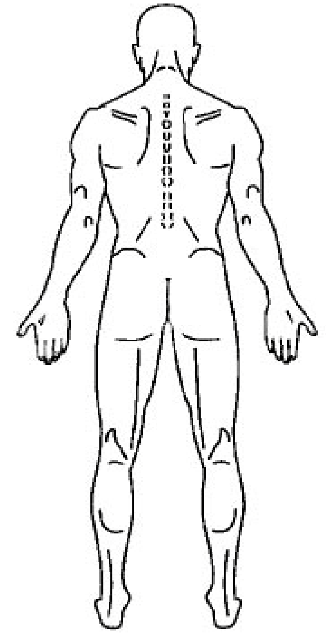
Musculoskeletal

O ☐ Headaches
O ☐ Neck problems
O ☐ Jaw pain or stiffness
O ☐ Jaw clicking
O ☐ Shoulder problems
O ☐ Arm problems
O ☐ Pain between shoulders
O ☐ Chest pain
O ☐ Lower back problems
O ☐ Leg problems
O ☐ Swollen joints
O ☐ Painful joints
O ☐ Stiff joints
O ☐ Sore muscles
O ☐ Weak muscles
O ☐ Walking problems
O ☐ Tendon ruptures
O ☐ Osteoporosis

Nervous System

O ☐ Numbness or tingling
O ☐ Loss of feeling
O ☐ Paralysis
O ☐ Dizziness
O ☐ Fainting
O ☐ Headaches
O ☐ Muscle jerking
O ☐ Convulsions
O ☐ Forgetfulness
O ☐ Confusion
O ☐ Depression
O ☐ Sleeping problems
O ☐ Nervousness
O ☐ Tension or stress
O ☐ Loss of memory
O ☐ Loss of balance
O ☐ Cold hands or feet
O ☐ Cold sweats

Please mark the areas of complaint and indicate their priority:

Gastro-Intestinal

O ☐ Poor appetite
O ☐ Excessive hunger
O ☐ Difficult swallowing
O ☐ Excessive thirst
O ☐ Nausea
O ☐ Vomiting food
O ☐ Vomiting blood
O ☐ Abdominal pain
O ☐ Diarrhea
O ☐ Constipation
O ☐ Bloody stool
O ☐ Hemorrhoids
O ☐ Liver trouble
O ☐ Gall bladder problems
O ☐ Weight trouble
O ☐ Stomach upset

Genito-Urinary

O ☐ Bowel/bladder trouble
O ☐ Excessive urination
O ☐ Painful urination
O ☐ Discolored urine

Female

O ☐ Vaginal discharge
O ☐ Vaginal bleeding
O ☐ Vaginal pain
O ☐ Breast pain
O ☐ Lumps on breast

Are You Pregnant?
☐ Yes ☐ No

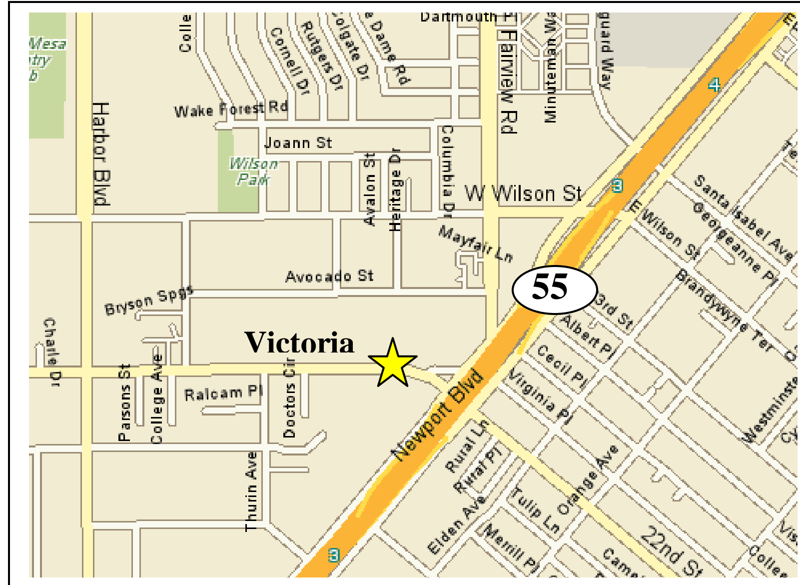
Cardiovascular

O ☐ Chest pain
O ☐ Difficulty breathing
O ☐ Persistent cough
O ☐ Coughing phlegm
O ☐ Coughing blood
O ☐ Rapid heartbeat
O ☐ Blood pressure condition
O ☐ Heart problems
O ☐ Lung problems
O ☐ Varicose veins

Eyes, Ears, Nose, Throat

O ☐ Eye strain
O ☐ Vision problems
O ☐ Ear pain
O ☐ Ringing in ears
O ☐ Hearing loss
O ☐ Vertigo
O ☐ Nose pain
O ☐ Nose bleeding
O ☐ Sinus problems
O ☐ Seasonal allergies
O ☐ Dental problems
O ☐ Fever
O ☐ Loss of smell or taste

How to Find Stately Chiropractic Group
275 Victoria St., Suite 2C, Costa Mesa, CA 92627
Phone: (949) 645-6325 Fax: (949) 645-6322



Major crossroads:
55 & Victoria

We are located between Armstrong Nursery and College Hospital on Victoria

HEADING SOUTH ON 405

1. Take the 73 S
2. To the 55 S
3. Exit Victoria/22nd St.
4. Turn Right on Victoria
5. Turn left into parking lot

HEADING NORTH ON 405

1. Take the 55 S
2. Exit Victoria/22nd St.
3. Turn Right on Victoria
4. Turn left into parking lot

FROM NEWPORT BCH.

1. Head towards Newport Blvd.(away from the beach)
2. Take the 55 N
3. Exit Victoria
4. Turn left into the parking lot.

FROM PCH

1. Turn onto Brookhurst
2. Turn Right onto Hamilton
3. Hamilton becomes Victoria
4. Turn Right into parking lot

HEADING NORTH ON 5

1. Take the 405 N
2. To the 55 S
3. Exit Victoria/22nd St.
4. Turn Right on Victoria
5. Turn left into parking lot

HEADING SOUTH ON 5

1. Take the 55 S
2. Exit Victoria/22nd St.
3. Turn Right on Victoria
4. Turn left into parking lot

HEADING NORTH ON 133 1. 1.Take the 73 S 2. To the 55 S 3. Exit Victoria/22nd St. 4. Turn Right on Victoria 5. Turn left into parking lot		

STATELY CHIROPRACTIC GROUP

275 Victoria Street • Suite 2C • Costa Mesa • CA • 92627

www.statelychiro.com

FINANCIAL ACKNOWLEDGEMENT AND UNDERSTANDING

_____Initials. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt.

_____Initials. I understand and agree that the portion of the charges due from me will be paid at the time of the office visit.

_____Initials. I understand and agree that I will be immediately responsible for paying any amounts that my insurance carrier has not paid within 60 days and that I will be subject to a $10 billing/late fee for any charges that become 90 days past due, unless payment arrangements have been made.

_____Initials. I also understand and agree that payment for Professional Services is due at the time services are rendered.

Patient or Parent/Legal Guardian's Signature:____

Date: ______________________________

CANCELLATION/LATE FEE POLICY ACKNOWLEDGEMENT AND UNDERSTANDING

_____Initials. I understand and agree that I will be responsible for a **$20 fee** for any cancellation or missed appointment, where a minimum 12 hour notice is not given. (Except in case of an emergency).

Please see copy of our updated policy.

Patient or Parent/Legal Guardian's Signature:________________________________

Date: ______________________________

NOTICE OF PRIVACY PRACTICES

April 13, 2008

STATELY CHIROPRACTIC GROUP, INC.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers including second opinions or referrals to specialists. Examples of treatment would include chiropractic manipulative therapies, myofascial release techniques, physiotherapy modalities, nutritional and exercise counseling, etc.
- **Payment** means such activities as obtaining reimbursement for services, confirming insurance coverage, billing or collection activities, and utilization review. An example of this would be billing your medical plan for our chiropractic services.
- **Health Care Operation** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services including release of information to friends and family members that are directly involved in your care or who assist in taking care of you. We will use and disclose your protected information when we are required to do so by federal, state or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information, to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding, response to a discover request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We will release your PROTECTED HEALTH INFORMATION if requested by a law enforcement official for

any circumstance required by law. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. We may disclose your PROTECTED HEALTH INFORMATION if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities. We may disclose your PROTECTED HEALTH INFORMATION to federal officials for intelligence and national security activities authorized by law. We may disclose PROTECTED HEALTH INFORMATION to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations. We may release your PROTECTED HEALTH INFORMATION for worker's compensation and similar programs.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- The right to request restrictions on certain uses and disclosures of PROTECTED HEALTH INFORMATION, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of PROTECTED HEALTH INFORMATION from us by alternative means or at alternative locations.
- The right to access, inspect and copy your PROTECTED HEALTH INFORMATION.
- The right to request an amendment to your PROTECTED HEALTH INFORMATION.
- The right to receive an accounting of disclosures of PROTECTED HEALTH INFORMATION outside of treatment, payment and health care operations.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your PROTECTED HEALTH INFORMATION and to provide you with notice of our legal duties and privacy practices with respect to PROTECTED HEALTH INFORMATION.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all PROTECTED HEALTH INFORMATION that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact:

Compliance Operations/Privacy Manager
Bari Swift, Office Manager
Stately Chiropractic Group, Inc.
275 Victoria St., Suite 2C
Costa Mesa, CA 92627
(949) 645-6325

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(877) 696-6775 (toll free)

Acknowledgment of Receipt of Privacy Practices

I,_____________________________ have received a copy of **Stately Chiropractic Group, Inc.'s** Notice of Privacy Practices with an effective date of April 13. 2003.

Signature of Patient _______________________ Date: ________

Signature of Witness ______________________ Date: ________

STATELY CHIROPRACTIC GROUP

275 Victoria Street • Suite 2C • Costa Mesa • CA • 92627

www.statelychiro.com

Informed Consent of Chiropractic Treatment and Care:

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and any other supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the chiropractor indicated below and/or other licensed Doctors of Chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the Doctor of Chiropractic named below, including those working at the clinic or office listed above or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the Doctor of Chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and like all other health modalities, results are not guaranteed, and there is no promise of cure. I further understand and am informed that, as in the practice of medicine, in the practice of chiropractic care there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited to, self-administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy, steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and to secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment..

______________________________ ______________________

Patient's Name (Please Print) Date

____

Patient or Guardian's Signature

I verbally gave the patient the material risks of proposed care.

☐Dr. Paul Stately, D.C. ☐Dr. Jorge Guevara, D.C. Date: ____________________

OSWESTRY LOW BACK PAIN SCALE

Please rate the severity of your pain by circling a number below:

No pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable pain

Name: ____ Date: _________________________

Instructions: Please circle the **ONE** number in each section which most closely describes your problem.

Section 1 - Pain Intensity

0. The pain comes and goes and is very mild.
1. The pain is mild and does not vary much.
2. The pain comes and goes and is moderate.
3. The pain is moderate and does not vary much.
4. The pain comes and goes and is severe.
5. The pain is severe and does not vary much.

Section 2 - Personal Care

0. I would not have to change my way of washing or dressing in order to avoid pain.
1. I do not normally change my way of washing or dressing even though it causes some pain.
2. Washing and dressing increase the pain but I manage not to change my way of doing it.
3. Washing and dressing increase the pain and I find it necessary to change my way of doing it.
4. Because of the pain I am unable to do some washing and dressing without help.
5. Because of the pain I am unable to do any washing and dresssing without help.

Section 3 - Lifting

0. I can lift heavy weights without extra pain.
1. I can lift heavy weights but it gives extra pain.
2. Pain prevents me from lifting heavy weights off the floor.
3. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table
4. Pain prevents me from lifting heavy weights but I can manage light-medium weights if they are conveniently positioned.
5. I can only lift very light weights at most.

Section 4 - Walking

0. I have no pain on walking.
1. I have some pain on walking but it does not increase with distance.
2. I cannot walk more than 1 mile without increasing pain.
3. I cannot walk more than 1/2 mile without increasing pain.
4. I cannot walk more than 3/4 mile without increasing pain.
5. I cannot walk at all without increasing pain.

Section 5 - Sitting

0. I can sit in any chair as long as I like.
1. I can sit only in my favorite chair as long as I like.
2. Pain prevents me from sitting more than 1 hour.
3. Pain prevents me from sitting more than 1/2 hour.
4. Pain prevents me from sitting more than 10 minutes.
5. I avoid sitting because it increases pain immediately.

Section 6 - Standing

0. I can stand as long as I want without pain.
1. I have some pain on standing but it does not increase with time.
2. I cannot stand for longer than 1 hour without increasing pain.
3. I cannot stand for longer than 1/2 hour wihtout increasing pain.
4. I cannot stand for longer than 10 min. without increasing pain.
5. I avoid standing because it increases the pain immediately.

Section 7 - Sleeping

0. I get no pain in bed.
1. I get pain in bed but it does not prevent me from sleeping well.
2. Because of pain my normal nights sleep is reduced by less than one-quarter.
3. Because of pain my normal nights sleep is reduced by less than one-half.
4. Because of pain my normal nights sleep is reduced by less than three-quarters.
5. Pain prevents me from sleeping at all.

Section 8 - Social Life

0. My social life is normal and gives me no pain.
1. My social life is normal but it increases the degree of pain.
2. Pain has no significant effect on my social life apart from limiting my more energetic interestes, e.g. dancing, etc.
3. Pain has restricted my social life and I do not go out very often.
4. Pain has restricted my social life to my home.
5. I have hardly any social life because of the pain.

Section 9 - Traveling

0. I get no pain when traveling.
1. I get some pain when travling but none of my usual forms of travel make it any worse.
2. I get extra pain while traveling but it does not compel me to seek alternate forms of travel.
3. I get extra pain while traveling which compels me to seek alternative forms of travel.
4. Pain retricts me to short necessary journeys under 1/2 hour.
5. Pain restricts all forms of travel.

Section 10 - Changing Degree of Pain

0. My pain is rapidly getting better
1. My pain fluctuates but is definitely getting better.
2. My pain seems to be getting better but improvement is slow.
3. My pain is neither getting better or worse.
4. My pain is gradually worsening.
5. My pain is rapidly worsening.

Total: _______________________

OSWESTRY NECK PAIN INDEX

Please rate the severity of your pain by circling a number below

No pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable pain

Name: ____ **Date:** ________________________________

Instructions: Please circle the **ONE** number in each section which most closely describes your problem.

Section 1 - Pain Intensity

0. I have no pain at the moment
1. The pain is very mild at the moment.
2. The pain comes and goes and is moderate.
3. The pain is fairly severe at the moment.
4. The pain is very severe at the moment.
5. The pain is the worst imaginable at the moment.

Section 2 - Sleeping

0. I have no trouble sleeping
1. My sleep is slightly disturbed (less than 1 hour sleepless)
2. My sleep is mildly disturbed (1-2 hours sleepless)
3. My sleep is moderately distrubed (2-3 hours sleepless)
4. My sleep is greatly disturbed (3-5 hours sleepless)
5. My sleep is completely disturbed (5-7 hours sleepless)

Section 3 - Reading

0. I can read as much as I want with no neck pain.
1. I can read as much as I want with slight neck pain.
2. I can read as much as I want with moderate neck pain.
3. I cannot read as much as I want because of moderate neck pain.
4. I can harldy read at all because of severe neck pain.
5. I cannot read at all because of neck pain.

Section 4 - Concentration

0. I can concentrate fully when I want with no difficulty.
1. I can concentrate fully when I want with slight difficulty.
2. I have a fair degree of difficulty concentrating when I want.
3. I have a lot of difficulty concentrating when I want.
4. I have a great deal of difficulty concentrating when I want.
5. I cannot concentrate at all.

Section 5 - Work

0. I can do as much work as I want.
1. I can only do my usual work but no more.
2. I can only do most of my usual work but no more.
3. I cannot do my usual work.
4. I can hardly do any work at all.
5. I cannot do any work at all.

Section 6 - Personal Care

0. I can look after myself normally without causing extra pain.
1. I can look after myself normally but it causes extra pain.
2. It is painful to look after myself and I am slow and careful.
3. I need some help but I manage most of my personal care.
4. I need help every day in most aspects of self care.
5. I do not get dressed. I wash with difficulty and stay in bed.

Section 7 - Lifting

0. I can lift heavy weights without extra pain.
1. I can lift heavyweights but it causes extra pain.
2. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g. on a table)
3. Pain prevents me from lifting heavy weights off the floor, but I can manage light - medium weights if they are conveniently located.
4. I can only lift very light weights.
5. I cannot lift or carry anything at all.

Section 8 - Driving

0. I can drive my car without any neck pain.
1. I can drive my car as long as I want with slight neck pain.
2. I can drive my car as long as I want with moderate neck pain.
3. I cannot drive my car as long as I want because of moderate neck pain.
4. I can hardly drive at all because of severe neck pain.
5. I cannot drive my car at all because of neck pain.

Section 9 - Recreation

0. I am able to engage in all my recreation activities without neck pain.
1. I am able to engage in all my usual recreation activities with some neck pain.
2. I am able to engage in most but not all my usual recreation activities because of neck pain.
3. I am only able to engage in a few of my usual recreation activities because of neck pain.
4. I can hardly do any recreation activities because of neck pain.
5. I cannot do any recreation activities at all.

Section 10 - Headaches

0. I have no headaches at all.
1. I have slight headaches which come infrequently.
2. I have moderate headaches which come infrequently.
3. I have moderate headaches which come frequently.
4. I have severe headaches which come frequently.
5. I have headaches almost all the time.

Total: ____________________________

Parking & Entrance Options

Parking is available in the front of the building (facing the Hospital) and in the back of the building facing Armstrong Nursery. Because the front parking fills up so fast and there rarely seems to be any spaces available, we recommend that you park in the back as there is always parking available. You may also park in the Armstrong Nursery parking lot or the Church parking lot as well.

There is an entrance to the building in the back, although it is not very clearly marked. The entrance is through a glass door that reads "this door to remain unlocked during business hours". (To the right of the picnic table). You will enter a hallway and once you go through the door, you turn left to go up the stairs or go right through another door to the elevator.

Dear Valued Patients:

We are an appointment only clinic, therefore, please keep in mind that we only take a limited number of people per day so that we can offer the highest quality care, and we staff accordingly. Our goal and mission statement is to see you on time, every time that you come in the office and give you the highest quality care on this planet!!!

We also value your time, and because of that, we strive to keep our schedule running smoothly and on time. We have had a huge increase in the amount of patients arriving late to their appointments, last minute cancellations, and not showing up for an appointment with no phone call. We do understand that the occasional emergency does happen, but when there are last minute cancellations or no shows, it does not allow us to get another person in, that really needs the care in that appointment time, not to mention that this may also change our staffing needs.

Our Policy is now as follows:

Cancellations must be made within 6 hours of your appointment time. (All other offices require 24 hour notice for cancellations). We do understand that the occasional emergency does happen. If you have a history of last minute cancellations, a $20 Missed Appointment Fee will be charged to your account.

No Shows will be charged a $20 Missed Appointment Fee after 1 warning.

Late Appointments If you are late for your scheduled appointment time, we will try our best to accommodate you by giving you the next available appointment time. If we are unable to accommodate you, we will need to reschedule your appointment.