



Military Chiropractic Care Program (MCCP)



2105 East Clairemont Avenue, Eau Claire, WI 54701 Phone: (715) 835-9514 Fax: (715) 835-2602

I, _____, understand that in order to qualify for the Military Chiropractic Care Program, I must meet the four requirements below:

1. I am a veteran of the Middle East.
2. I have completed my tour of duty (not on leave).
3. I am not currently under chiropractic care at this or any other clinic.
4. I have a DD214 form which verifies my completing my tour of duty.

By signing here I certify all conditions have been met.

Signature: _____ Date: _____

I fully understand that I am being offered one year of chiropractic care at no charge beginning on ___/___/___, ending ___/___/___ . This care includes:

- Initial Consultation and examination along with follow up exams.
- Any necessary x-rays
- All chiropractic adjustments and therapies as recommended to me by the doctor.

I also fully understand this excludes:

- Supplements
- Products (pillows, orthotics, mattresses, etc.)

and that standard prices will apply.

In addition, I fully understand that at the end of one year of care, if I choose to remain a patient of this clinic, usual and customary fees will apply. If I choose to use insurance, I will be responsible for payments according to my insurance plan.

By signing below, I fully understand and agree to the above terms of this contract.

Pt. Signature: _____ Date: _____

CA Signature: _____ Date: _____