MFR & PT,

MASONS'

A personal approach to your healing journey

New Patient Information

Last Name	First Name	Date of Birth	Age
Address		Home Phone	
City	State Zip	Mobile phone	
Email		Fax	

Emergency Contact Information

Name	Relationship	Phone

Referring Physician Information

Name	Phone

Acknowledgement of HIPAA Privacy Policy

We at Masons' Myofascial & Physical Therapy are required by law to maintain the privacy of and provide individuals with an explanation of our legal duties and privacy practices with respect to private health information.

Signature_____ **Date** _____

Consent to Treat

I am financially responsible for services. I hereby give permission to the therapist to administer treatment and perform such general procedures as deemed necessary in the diagnosis and/or treatment of my condition. I hereby authorize and request any/all physicians involved in my care to release to Mason Myofascial & Physical Therapy the complete history records in their possession concerning any treatment or examination rendered to me in the treatment of this diagnosis.

Signature_____ **Date** _____

Cancellation and Payment Policy

I understand that I will be charged and expected to pay a cancellation fee of $125 if I fail to cancel an appointment at least 24 hours in advance of the appointment time. I understand that payment is due in full at the time of service. I understand that it is my responsibility to collect reimbursement from my private insurance company using the superbill provided if I so desire.

Signature_____ **Date** _____