



## Wholistic Physical Therapy, P.C.

### Welcome to Wholistic Physical Therapy, a Myofascial Release Treatment Center.

We would like to take this opportunity to thank you for choosing our facility and we look forward to assisting you in your healing process.

We aim to provide the expertise, guidance, environment and therapeutic treatment to help you achieve your goals and enhance your ability to return to a pain-free, active lifestyle.

People are referred to the Myofascial Release Treatment Center from a wide geographical area, for the resolution of complex problems that have failed to respond to conventional medications, surgery, and therapeutic treatments. A Doctor's prescription is eventually required for care from a Physical Therapist. Wholistic physical therapy is dedicated to the comprehensive delivery of the highest quality care utilizing a multifaceted, multidisciplinary approach for lasting results.

We are not contracted with any insurance companies other than Medicare. However, the payments you make are reimbursable by your insurance company under your out of network physical therapy benefits. The exact percentage depends upon your plan. We will assist you in every way possible. Unless you are a Medicare beneficiary, payment is due at the time of service. Fees are \$195 per treatment, and \$295 for Initial Evaluation and treatment.

We request that all clients extend a courteous 48-hr cancellation notice to change or cancel any appointment. If less than a 48hr notice is given frequently, the session fee may apply.

Office hours in the Midtown WPT office are available currently Monday through Friday. We would appreciate your cooperation and courtesy in keeping your scheduled appointment times as well as notifying us of any delays, since this time is set aside specifically for you and only you.

Please note that e-mail addresses and contact information will be used only to forward educational material and for professional reasons. Your record is held in the utmost confidence.

I have read and understand the above office policy. I hereby agree to pay directly this office for professional services rendered and shall be personally responsible for any unpaid balance to this office. I hereby authorize the attending therapist to release any information concerning my examination or treatments to my insurance carrier or other medical professionals involved in my care.

Print Patient's Name \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_