



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.

Other than Medicare, we are not contracted with any insurance companies. 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 assessed hourly and are \$140 per hour.

We request that all clients extend a courteous 24-hr cancellation notice to change or cancel any appointment. If less than a 24hr notice is given, the session fee will apply in a discretionary fashion.

Office hours are: Monday, Tuesday and Wednesday from 9am to 8pm. Thursday, Friday and Saturday from 8am to 5pm. We would appreciate your cooperation and courtesy in keeping your scheduled appointment times as well as notifying us of any delays.

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.

Photographs taken during initial evaluation, progress evaluation and discharge summary will be used for postural comparison purposes and as educational tools. By signing below you consent to the use of these photographs in a professional manner.

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 _____