FINANCIAL AGREEMENT

I understand that I am fully responsible for payment of services with cash, check or credit card and agree to pay Mindy L. Cohen, PT. at the time that the professional services are rendered.

A photocopy of this assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved with this case.

I understand that if I am unable to keep an appointment, I must provide 24 hours notice of cancellation. If sufficient notice is not received, I will be billed $100.00 for the missed appointment.

I certify that all information provided on the "client information" sheet is true and correct to the best of my knowledge. I will notify you if my health status or the stated information changes.

I hereby request and consent to treatment from Mindy L. Cohen, PT. I understand that my treatment may require the provision of varied therapies including, but not limited to Physical Therapy, CranioSacral Therapy, SomatoEmotional Release, Myofascial Release, Lymphatic Drainage, Muscle Energy techniques and other manual therapies. I realize that the particular therapeutic outcomes of these treatments, individually and jointly, can not be predicted with certainty and no guarantee is made regarding any particular result or outcome.

SIGNATURE:_____DATE:_____

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IF THE CLIENT IS UNDER 18, PLEASE COMPLETE THE FOLLOWING:

NAME OF LEGAL PARENTS OR
GUARDIAN:_____ DATE:_____