

Medical Massage Center, Inc.

Patient Information

Patient Name _____
Address _____ City _____ Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____
E-mail Address _____
SSN _____ - _____ Sex M / F Birth Date: _____ / _____ / _____ Marital Status S M D W
Employer's Name _____
Address _____
Occupation _____

How did you learn of Medical Massage Center, Inc.? Please check all that apply.

- | | |
|---|---|
| <input type="checkbox"/> Doctor Referral, name: _____ | <input type="checkbox"/> Yellow Pages Denver / Local (circle one) |
| <input type="checkbox"/> Other Professional: _____ | <input type="checkbox"/> White Pages: _____ |
| <input type="checkbox"/> Sign on Building: _____ | <input type="checkbox"/> Welcome Wagon: _____ |
| <input type="checkbox"/> Friend/relative, name: _____ | <input type="checkbox"/> Website: _____ |

Payment in full is due at the time of service unless other arrangements have been made with this office.

I authorize the release of any medical or other information concerning my present illness or injury to my current medical provider(s).

Signature _____ Date _____

CANCELLATION POLICY

Medical Massage Center, Inc. has adopted a **24 hour cancellation policy**. We require notification **24 hours in advance** if you cannot keep your appointment. Since we set aside one hour for each appointment, it is only respectful of our time and others who wish to be seen that you give adequate notice.

We certainly understand that extenuating circumstances can arise over which you have no control. However, please be advised that we will charge \$25.00 in the event that an appointment is missed. This is a charge for which your insurance company is not responsible; therefore, it will be billed directly to you.

Thank you, in advance, for your consideration of our time and the time of our other clients.

I have read and understand the above policy, and agree to abide by it while being treated at Medical Massage Center, Inc.

Patient Signature

Date