DATE: _____ (mm/dd/yyyy)

Susan C. Jackson & Associates

Therapeutic and Relaxation massage

Restoring, Maintaining & Enhancing your well being!

POLICIES & PRINCIPLES:

1. All clinic patients MUST COMPLETE A CASE HISTORY FORM. The INITIAL VISIT will include a review of this case history, assessment, and blood pressure reading.
2. Your massage therapy treatment is booked for an hour appointment time. Therefore, all aspects of your treatment will fit into that appointment time, i.e. homecare, hydrotherapy, remedial exercise, etc.
3. MISSED appointments must be notified 24 HOURS in advance or payment is required.
4. **IF FOR ANY REASON THE CLIENT'S INSURANCE COMPANY DOES NOT PAY, THE CLIENT WILL BE RESPONSIBLE FOR THE OUTSTANDING BALANCE and understands that they are completely responsible for payment of treatment(s).**

Name: _____

Birthdate (mm/dd/yyyy): _____

Email: _____

Address: _____

_____ Postal Code: _____

Phone numbers:

Cell: _____ Home: _____ Work: _____

Occupation: _____

Primary Insurance Holder: _____

Insurance Company: _____

Group/Policy#:_____ Cert./ID#: _____

Family Physician: _____

How did you become aware of our clinic? _____

Reason for your visit:

Main Complaint: _____

Other Complaints: _____