EssentialMFR
Advanced Wholistic Body Therapy

WELCOME LETTER

We would like to take this opportunity to thank you for choosing Essential MFR for your alternative healthcare needs. Our aim is 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 life style. People are referred to Myofascial Release (MFR) treatment for the resolution of complex problems that have failed to respond to conventional medications, surgery and therapeutic treatments. As your MFR therapists, we are dedicated to the comprehensive delivery of the highest quality care utilizing a multifaceted, multidisciplinary approach for lasting results.

Payment is due at the time of service. The initial MFR session which includes an evaluation and a treatment session is approximately seventy-five to ninety minutes in length. Subsequent treatments are assessed quarterly and can range from sixty-one hundred and twenty minutes in duration. Cash, personal checks and credit cards are accepted.

We request that all clients extend a courteous 24-hr cancellation notice to change or cancel any appointment. If less than 24 hrs notice is given, a charge of 50% of you're treatment price or a deduction of a package unit, whichever is the lessor, will be assessed.

With regards to attire during treatment sessions; Myofascial Release treatment techniques are done on skin, so a 2-piece bathing suit, underwear, tank top and shorts or whatever you are comfortable with wearing is appropriate.
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.

Patient: I, _____, have read and understand the above policy. I hereby agree to pay directly this clinician 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.

Signature: _____Date:_____

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