



Rolfing® Structural Integration Client Financial Responsibility

Client Name: _____ Date: _____

By choosing to participate in sessions, you are agreeing to the following (please initial each statement whether you are using insurance or not):

____ I agree to pay my FULL PAYMENT AT THE TIME OF SERVICE (if no insurance is applicable).

____ I acknowledge and understand that I AM SOLEY AND ULTIMATELY RESPONSIBLE for and all charges for professional services provided.

If insurance is applicable:

____ I agree to pay my COPAYMENT AT THE TIME OF SERVICE and am responsible for any amount not covered by my insurance. I am responsible for knowing my insurance coverage and benefits.

____ I authorize the release of any client information that may be requested by my insurance company.

Cancellation/No-Show Policy:

There may be times when you miss an appointment due to emergencies or obligations to work or family.

Please call the office at _____ at least 24-hours prior to your appointment time to cancel or reschedule your appointment.

____ I understand that if I miss an appointment without canceling in advance I will be charged a no-show fee of _____.

I have read the above policy regarding my financial responsibility for providing services to me. I certify that the information is, to the best of my knowledge, true and accurate.

Date: _____

Client or Legal Guardian Signature: _____

For child client, Legal Guardian Name: _____

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