S.A.M.I. Myofascial Release
Consent to Treatment

1. I hereby consent to the treatment necessary to help determine the recommended course of care and to administer what is deemed necessary to treat my present condition. I understand that there are certain risks and benefits to administering physical treatment. It is my understanding that such risk factors may be explained to me upon my request by the treating practitioner. I understand that I may choose to refuse or cease treatment at any point I deem necessary during treatment. I have the right to discuss the nature, purpose, and risks of treatment.

   Initials: _____

2. I have disclosed my complete medical history. I have not withheld any information that could put my practitioner or myself at risk. I understand that my practitioner is not a healthcare physician and cannot prescribe drugs or diagnose my condition.

   Initials: _____

3. I understand that a 24-hour cancellation policy means that I will give no less than a 24-hour notice of cancellation or I will be subject to a cancellation fee. If I do not show for a session, I will be charged the full price. I understand that there are no refunds for missed sessions or sessions that have already been performed. My sessions will expire 12 months from the date of purchase.

   Initials: _____

4. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), S.A.M.I. Myofascial Release must take steps to protect the privacy of your "Protected Health Information" (PHI). PHI includes information that we have created or received regarding your health or payment for your health. Your signature indicates your receipt and acknowledgement of our **Notice of Privacy Practices,** which explains our duties and practices regarding your PHI.

Print_____ Practitioner: Muraad Pope

Sign_____

Date_____

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