Rachel Berger, MSPT

318 Harvard Street #30, Brookline, MA 02446

New Patient Information

Patient Name:_____ Date of Birth: _____

Phone Number (h):_____ (w): _____

(cell): _____ Email: _____

Address:_____City/State: _____ Zip:_____

Ocupation: _____ Employer: _____

If you are a minor, guardian name:_____ Relationship to you:_____

Reason for your visit today: _____

Have you had physical therapy for the same condition Yes No If yes, when? _____

Have you had physical therapy for a different condition? Yes No If yes, when and for what?
_____

Goals you wish to achieve while receiving services: _____
_____

Primary Care Physician: _____ Phone #: _____

Referring Physician: _____ Phone # : _____

Cancellation Policy

Please provide at least 24 hours notice to cancel an appointment. For appointments missed or cancelled without notice, charge will be **$50.00** if I am unable to fill the slot, regardless of if you are self pay or insurance based.

Authorization For Treatment and Release of Records

I hereby authorize the performance of physical therapy by Rachel Berger, M.S.P.T.. This care is provided at my request.
I further authorize the release of medical and/or billing information regarding my care as necessary.

Payment Policy

If applicable, my insurance will be billed for my physical therapy visits. If the visits are not covered under my plan, or the visits have been denied payment, I agree to pay for the visits as an out of pocket expense.

Patient Signature: _____ Date: _____