

PRESCRIPTION EXPIRATION REMINDER AGREEMENT

I, _____, have received the prescription expiration reminder from _____

And understand that my failure to renew my prescription will result in being financially responsible to cover any lapsed visits. I understand what must be on the prescription and I know that my insurance will only cover any visits with a valid prescription that has:

1. Patient Name and Date of Birth
2. A diagnosis code/description
3. Is written by an MD, DO, PA or Chiropractor for a musculoskeletal issue
4. Is prescribed for Massage Therapy, NOT Physical Therapy
5. Physicians name, address, and phone number
6. Prescripts start on the date it is written, not the date you start treatment. If there is no term mentioned, it is good for one year.

Patient Name Print: _____

Signature: _____

Date: ___ / ___ / _____

For Office Use:

Prescription Start Date: ___ / ___ / _____

Prescription End Date: ___ / ___ / _____