NEW PATIENT INFORMATION

JODY HENDRYX, PT
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512-789-9467

Name:	Date:
Address	
Date of Birth	Phone number:
Email Address:	
Referring Provider (if any):	

_____ I do hereby agree and give my consent for Jody Hendryx, PT to furnish care and treatment that is considered necessary and proper in the treatment of my physical condition. I understand that I retain the right to revoke this consent at any time.

_____24 hours are requested for cancellation of appointments. I understand that I will be charged for my appointment for non emergency cancellations less then 24 hours.

_____Jody Hendryx, PT is not a provider for Medicare. I understand that no claim to Medicare may be made for services received with Jody Hendryx, PT.

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Signature of Patient Date