



**Brande Moffatt, MPT, PRPC**  
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### **ADDENDUM FOR PRIVATE PAY**

**This notice is to inform you that the initial 60 minute new patient eval/treat will be \$165. All subsequent follow-up visits will be \$140 per each 1 hour visit.**

**With my signature, I am acknowledging that I understand payment is due at the time services are rendered.**

**Please be advised that we collect a \$50.00 no-show fee for cancellations with less than 48 hour notice. Late arrivals will be charged the fee for the entire visit.**

**I have read the above information and I consent to physical therapy evaluation and treatment.**

**Print Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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**Patient/Guardian Signature:**