APPOINTMENT CANCELLATION POLICY

EFFECTIVE JANUARY 1, 2015

Healing Hands Physical Therapy must have at least 24-hour notice for cancelling a scheduled appointment. For Monday appointments, please cancel the preceding Friday by 3:00 pm.

Cancelling less than 24 hours prior to your appointment may result in a **$50.00 cancellation fee**. If we can fill the appointment slot, the fee may be waived. Emergency situations will be considered on a case by case basis. After more than a combination of 3 late cancellations, No Shows or excessive rescheduling, you may be discharged for failure to meet the plan of care.

Please arrive on time for each appointment so you can take full advantage of the time that has been reserved for you. If you arrive late, your appointment may be shortened.

It is important you come to every scheduled appointment. When you miss an appointment, it:

1. Affects your Treatment Plan and progress
2. Affects the Therapists
3. Prevents us from seeing another patient

I have read and understand the Healing Hands Therapy Cancellation Policy.

_____ _____

Patient Signature (or authorized signature) Date

_____

Printed Name of Patient

Healing Hands Physical Therapy
210 Little Lake Dr., Suite 8, Ann Arbor, MI 48103
Phone: (734) 222-8515 Fax: (734) 222-8520

Healing Hands Physical Therapy Authorization Form

Thank you for choosing Healing Hands Physical Therapy as your physical therapy provider. If you have any questions or concerns about our policies, please do not hesitate to contact us. Please read and sign this form prior to your services.

CONSENT: I consent to the physical therapy that was ordered by my physician. I understand and agree that such physical therapy services will be provided by a specialized health care provider under the direction of my physician. I acknowledge that no guarantees have been made to me concerning the result of treatment and/or diagnostic procedures.

AUTHORIZATION: I authorize the release of any and all medical records concerning my treatments to my insurance company if needed for payment or reimbursement for services rendered to me. This is in compliance with the Health Insurance Portability and Accountability Act (HIPAA) as outlined in the notice of privacy practice displayed in the treatment room. I understand that a copy will be made available to me upon my request.

DIRECT PAYMENT: I authorize direct payment to Healing Hands Therapy, LTD of all benefits otherwise payable to me for care and treatment at the clinic, but not to exceed its regular charges, and I address those benefits to Healing Hands Therapy, LTD. I certify that the information provided by me is correct.

FINANCIAL RESPONSIBILITY: I agree to pay in full any and all charges for services not payable or covered by my insurance carrier or other benefits. I understand that this balance is to be paid within ten (10) business days or it could result in legal action. In addition, I understand that there will be a $35.00 charge for all returned checks.

INSURANCE INFORMATION: I understand that it is my responsibility to contact my insurance company if payment has not been made within 45 days of service.

This authorization is in effect for all future claims, until I choose to revoke it in writing.

I, the undersigned, understand and agree to the above financial policy. I further understand that I am financially responsible for all charges incurred for my medical treatment.

_____ _____

Patient's Signature (or authorized signature) Date

_____ _____

Printed Name of Patient Relationship to Patient (if not patient)

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INSURANCE BILLING

Please contact your insurance's customer service department to verify your deductible, co-pay, or co-insurance responsibility. We cannot validate or guarantee your benefits. The exact amount of your responsibility under your insurance contract will be reflected on the Explanation of Benefits from your insurance company and our billing statement. Thank you for your continuing cooperation.

By signing below, I understand that I am responsible for payment of any services rendered that are not covered by my insurance company. The Description of Benefits from my insurance company is a quote, not an authorization or guarantee of payment. Co-pays, co-insurance and remaining deductibles are due at the time of treatment.

_____ _____

Patient's Signature (or authorized signature) Date

_____ _____

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