



HIGHLINE THERAPY SERVICES
 PHYSICAL ■ OCCUPATIONAL ■ SPEECH
 SPORT & SPINE REHAB

Patient Name: _____

MISSED APPOINTMENT POLICY

*It is very important for your recovery that you attend all your scheduled therapy treatments. **WE REQUIRE 24 HOURS NOTICE IF YOU ARE UNABLE TO KEEP YOUR APPOINTMENT.** A \$25.00 fee may apply after a missed appointment if proper notice is not given*.*

- *If you fail to show or cancel 2 appointments, all remaining appointments may be removed from the schedule.*
 _____ Patient Initials
 - *If you wish to continue with your therapy, then you must call the day of to schedule an appointment. You may also choose to pay a \$25 fee to resume advanced scheduling.* _____ Patient Initials

** Massage Therapy Clients: \$25.00 missed appointment fee will apply after the second missed appointment.*
 _____ Patient Initials

CO-PAYS

If your insurance has a co-pay, it is due at the time of service. The fee for billing outstanding co-pay(s) is \$20.00.

TERMS OF PAYMENT

A claim will be submitted to your insurance company on your behalf. Your portion of your bill is due within 10 days of receipt of HTS statement. A re-billing charge of 1% per month is added to account balances over 60 days.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been given a copy of Highline Therapy Services' Notice of Privacy Practices that describes how my health information is used and shared. I understand HTS has the right to change this Notice at any time. I may obtain a current copy by contacting the clinic or the billing office.

HTS has my authorization to release billing information and/or condition information to:

- Myself and my insurance carrier
- My Spouse
- My immediate family
- My employer
- Other: _____

My signature below constitutes my acknowledgement that I have been provided with a copy of the Notice of Privacy Practices and that I have authorized Highline Therapy Services to discuss my billing information and/or condition with the people above.

RELEASE OF BENEFITS AND INFORMATION

I authorize my insurance benefits to be paid directly to Highline Therapy Services (HTS). I am responsible for all co-payments, deductibles, and non-covered services as determined by my insurance plan at the time of claims processing. I have read HTS's billing policy. I authorize HTS or my insurance company to release any information required for processing of this claim per HTS's Notice of Privacy Practices. I consent to receive treatment as prescribed by my doctor. A copy of this authorization shall be as valid as the original.

 Signature of Patient or Guardian

 Today's Date

IMPORTANT NOTICE: *We strongly recommend you call your insurance company to verify Physical, Occupational, and/or Speech Therapy benefits. There may be dollar and/or visit limits, preauthorization/referral requirements, or other restrictions. If you have further questions, please contact our business office at 253-874-2998.*