



Patient Policies and Authorizations

APPOINTMENTS:

Please arrive for your initial appointment at least **10 minutes early**.

If you are more than **15 minutes late** for your appointment without contacting us, your treatment may need to be adjusted or your appointment rescheduled.

Inform the front desk staff immediately of any demographic changes (phone number, address, insurance etc). Failure to notify us of changes to your insurance coverage and/or financial status may result in you being responsible for payment of services not covered by insurance carrier.

*****CANCELLATION POLICY:** A fee of \$30.00 may be imposed after the second appointment that is missed or cancelled with less than 24 hour notice. ***

INSURANCE INFORMATION: We must emphasize that our relationship is with you, **not** your insurance company. Submission of insurance claims is a courtesy we extend to our patients but all charges are ultimately the patient's responsibility.

It is our policy to verify each patient's therapy benefits with their insurance company prior to their initial visit and to notify the patient of their coverage. Your coverage is a contract between you and your insurance company. It is important that you contact your insurance company directly with any questions for clarification and final decisions regarding your benefits. The patient is responsible to notify our office of any change in their insurance coverage.

If you have insurance coverage under a plan with which we do not participate you will be given the option to receive care as a self-pay patient. If you chose to use out of network benefits, you need to be aware that any balances not covered by your insurance become your responsibility.

Co-pays and self-pay amounts are due at the time of service. Any deductible and/or coinsurance amounts due from you will be billed to you.

PAYMENT: Prana Functional Manual Therapy is committed to providing you with the best care possible. If you have medical insurance, we will do everything possible to assist you in receiving your maximum insurance benefit.

We accept cash, personal check, money order and most major credit cards in person or by phone. Credit card payments are also accepted by phone.

Any outstanding balances are due within 30 days unless prior arrangements have been made.

PAYMENT PLANS: Please contact our billing specialist to work out a payment plan with our office. We will be happy to work with you in order to pay any balance due to our office.

***All balances that reach 90 days or older from the date of service may be sent to a collection agency. Accounts referred to a collection agency may be subject to a collection fee of 20% which will be added to the total balance due at the time the account is turned over. ***

PAYMENT AGREEMENT: I agree that I am responsible for payment of charges which are not covered, allowed, or paid by my insurance company, Medicare, or any other Fund or third party payor. I understand that I will not be responsible for payment of any charges that Prana FMT is restricted from collecting by law or agreement. With the assignment described in this consent, I understand that any check for payment of benefits sent directly to me belongs to Prana Functional Manual Therapy.

_____initials

CONSENT FOR TREATMENT: I hereby give my consent to receive treatment at Prana Functional Manual Therapy and authorize its employees to treat me in ways they judge beneficial to me. I understand my care may include evaluation, testing and treatment. I understand Prana Functional Manual Therapy cannot predict or guarantee the outcome of this care.

_____initials

RELEASE OF INFORMATION: I authorize Prana Functional Manual Therapy to release all information including all or part of my medical records to my insurance company, employer (worker's compensation only), Medicare, or Fund or third party payor which may be responsible for payment of my benefits.

I authorize Prana Functional Manual Therapy to obtain medical records and/or professional information from my physician or other medical professionals as it relates to my treatment.

Prana Functional Manual Therapy may also release information to the following person(s):

Example: Attorney, Family members or friends

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I have read and fully understand the patient policies and authorizations set forth by Prana Functional Manual Therapy and I agree to the terms of this policy.

Date: _____ Signature: _____

Prana Functional Manual Therapy follows Health Insurance Portability and Accountability Act (HIPAA). Should you like a copy of this Privacy Notification, please ask the front desk. Please sign below to acknowledge a copy is readily available should you want one.

Date: _____ Signature: _____