Healing In Motion PLLC Therapy and Wellness Center
5340 Plymouth Rd, Ste.100 Ann Arbor, MI 48105 Phone 734.913.4816 Fax 734.913.8021

Occupational & Physical Therapy and Wellness: Informed Consent, Financial Authorization & Cancellation Policy

1. I understand that I have a condition requiring treatment and do hereby voluntarily consent to rehabilitative treatment as deemed necessary or advisable by the physician who referred me, their assistants or designees, the employees of Healing In Motion, and/or myself.

2. I understand that I have the right to consent or refuse to any proposed procedure or therapeutic course during my care.

3. I understand that not all therapists at Healing In Motion are employees or agents of Healing In Motion, but rather may be independent contractors who have been privileged to provide medical or therapeutic treatment.

4. I understand that practice of medicine is not an exact science and that evaluation and treatment may involve risk of injury, or even death. I understand that no guarantees have been made to me as to the result of examination or treatment at Healing In Motion. My treatment is based on my physician's determination of my need, if legally required.

5. No person may bring into Healing In Motion any illegal drugs, toxic substances, weapons or alcoholic beverages. Any illegal drugs, toxic substances, weapons or alcoholic beverages may be seized and turned over to appropriate authorities and that person may be discharged and/or prosecuted.

6. I understand that smoking is not permitted inside the building.

7. Healing In Motion requests that patients refrain from use of excessive perfumes or colognes.

8. I understand that if I violate the policies of Healing In Motion, I may be discharged as a patient.

9. I understand that Healing In Motion is not responsible for the loss or damage to my personal items including, but not limited to eye glasses, canes, clothing, jewelry, hearing aids or like items.

10. I authorize Healing In Motion to release information from my medical record including: information about communicable and serious communicable diseases and infections as defined by the statue and Michigan Department of Public Health rules (including Venereal Disease, Tuberculosis, Hepatitis B, Human Immuno-Deficiency Virus, Acquired Immuno-Deficiency Syndrome and AIDS-related complex); substance abuse treatment protected by 42 code of Federal Regulations part 2; psychological and social services information including communications made by me to a psychologist or social worker to:

- **a.** Any third party payor or insurance company responsible in whole or part for paying my medical bill so that Healing In Motion may be paid for services.
- **b.** Any professional staff member or their designee involved in my medical care.
- **c.** Any independent auditors/reviewers or staff retained by any third party payor, of Healing In Motion, private health insurers or any employer providing health insurance benefits to me for the purpose of analyzing Healing In Motion charges as necessary to obtain payment for services and/or required review or audit of that payment by the payor.
- **d.** Any health care facility, provider, physician or other entity or to my primary care provider for continuity of care.
- **e.** Any accrediting or regulatory agency that may require mandatory data collection or review. Note: my consent to release information for billing purposes extends to any audit of billing records, which may occur after the payment of my bill.

INITIAL:_____

11. If I, as a patient, am eligible for or entitled to, medical benefits of any type from any insurance policy or benefits plan or from any other responsible party, such benefits are hereby assigned to Healing In Motion for application on my bill at Healing In Motion, and Healing In Motion may obtain payment under such benefits.

12. I agree that, whether I am the patient or I am signing on behalf of the patient, I will be individually obligated to pay for services on behalf of the patient, not covered by insurance or other benefit plan, including co-pay and deductible amounts. I agree to pay for services upon receipt of the bill. I authorize Healing In Motion to pursue collection action necessary to obtain payment if I do not pay for the services in a timely manner. I understand that I am responsible for expenses, including attorney fees, to pursue collection of the bill.

13. I understand that in order for any therapy treatment to be effective, I must come to scheduled appointments unless there are unusual circumstances that prevent me from attending therapy. I understand and agree to cooperate with and perform the home therapy program intended for me. If I have trouble with any part of my treatment program, I will discuss it with my therapist.

14. Financial Policy: I agree to pay for my treatments at time of service, by cash, check, or charge card unless other mutually agreed upon arrangements have been made. **I understand it is my responsibility to know my individual policy coverage and to obtain any pre-authorization necessary, prior to my appointment**. I understand that if Chicagoland Medical Billing submits on my behalf, it may take 30 days or more for reimbursement.

INITIAL: _____

15. In addition to co-pays, your therapist may suggest minor equipment or supplies to assist you with your home program needs. These items may be offered as a convenience to our clients and may be available for purchase at Healing In Motion. If you choose to purchase items at Healing In Motion, payment is expected at the time they are received by the client.

INITIAL: _____

16. I acknowledge that I was provided the opportunity to accept/decline a copy of Healing In Motion's Notice of Privacy Practices. Please identify below your wishes regarding communications from Healing In Motion:

_____ Leave a message at my home/cell and/or answering machine regarding appointment scheduling.

_____ Leave a message at my home/cell requesting a return call.

_____ Send a text message to my cell phone for scheduling and reminders.

_____ Leave a message at my office requesting a return call. Office Number _____

_____ Leave a message on my office voicemail regarding my healthcare/ appointments.

_____ May speak with _____ regarding my care. (please specify name)

_____ May add my name to receive email newsletters and promotions. Email _____

17. Cancellation Policy: I understand that if I cancel more than 24 hours in advance, I will not be charged. I understand that if I cancel less than 24 hours in advance, I will pay a cancellation fee of $50. Additional fees will be charged for 2 therapists or longer treatment times. Please choose one of the following options:

_____ Please do NOT give me a reminder call for my appointments.

_____ Please give me reminder calls/emails for all appointments.

Best phone number for reminder call: _____

Best email address for reminder email: _____

Which of the following are you being seen for: _____Occupational Therapy _____ Physical Therapy _____Wellness

I have read the above information, understand it and consent to evaluation and treatment. I have asked any questions and they have been answered to my satisfaction. I understand the risks, benefits and alternatives to treatment. I hereby voluntarily consent to treatment. I understand that I may choose to discontinue treatment at any time.

_____ _____ _____

Printed Name (patient, parent legal guardian or patient advocate) Relationship Date

_____ _____

Signature Date

_____ _____

Signature of Witness Date