HIPAA Compliance Patient Consent and Payment Policy

I, ____________________________, acknowledge Advanced Rehabilitation and Health
(Print Name)
Specialists are in compliance with all HIPAA and Privacy Policies.

I authorize Advance Rehabilitation and Health Specialists to discuss my health information with the following individuals:

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* **CANCELLATION POLICY**. Should you need to <u>cancel/reschedule</u> an appointment please do so <u>24-Hours</u> before your appointment time. Failure to do so **will result in a $25 charge** to your account. We realize emergencies arise and are sometimes unavoidable, however, advanced notification allows us to keep the office operating efficiently.

***YOUR CO-PAY IS DUE AT EACH VISIT**. Should your Insurance deny payment, you will be responsible for outstanding charges. If your Insurance pays you, you will remit payments to ARHS.

***PATIENT ACCOUNT POLICY**. A Patient's account is not allowed to exceed more than $300 and/or 30 days past due. If this should occur the patient **will be required** to make payment in full before care will be continued.

I understand my Insurance benefits, and will promptly pay what I owe. ARHS accepts cask, check, or Credit card. I agree with the plan of care that the therapist has discussed.

Date: ____________ Patient Signature: ____

Parent Signature if Patient is under 18: ____________________________________