orthomotion

Orthomotion Inc. Therapy Policies

- **Cancellation Policy:** It is our intention at ***Orthomotion Inc.*** to provide all of our patients with the best possible service. In fairness to all of our patients as well as our therapists, we ask that you contact us within 48 hours of a cancellation so that we may accommodate our other patients' needs for appointments. Please be aware that we cannot bill your insurance company for the $55.00 last minute cancellation/no show fee, which you will incur for cancellations with under 48 hours' notice. For Monday appointments, cancellations MUST be received by 2pm the preceding Friday. We thank you for your understanding and consideration of ***Orthomotion Inc***. staff as well as fellow patients.
- **Payment at the time of service:** We are happy to bill your insurance, collect copays, deductibles, and cost of treatment if insurance is not being billed. We will collect from you all outstanding balances prior to your treatment.
- **Insurance:** ***Orthomotion Inc.*** will verify your benefits, and work to ensure that you receive benefits. However, please be aware that you are ultimately responsible for understanding your insurance benefits for Occupational/Physical Therapy, and for the charges accrued as a patient of ***Orthomotion Inc.***

Print Name _____**Signature**_____ **Date**_____

Authorization Benefit Assignment – Financial Responsibility – Release of Information

I authorize ***Orthomotion Inc***. to release to the insurance carrier, any information needed for the payment of any claim. I authorize and hereby assign payment directly to ***Orthomotion Inc.*** from my insurance carrier or third party payer.
I agree to pay any applicable co-payments, co-insurance and/or deductible amounts for which I am responsible under my insurance policy at the time of service. I understand that my insurance benefits may not cover all charges and that I am responsible for those charges not covered by my health insurance or third party payer. All bills for services are due upon receipt, and any balance that remains unpaid for 30 days or longer will be charged a $35 late fee.
I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees in addition to my outstanding balance. I understand that my credit card number will be kept on file for any applicable fees to be charged in the event of non-payment. A photocopy of this authorization is to be considered as valid as the original.
By my signature, I authorize ***Orhomotion Inc.,*** to release all information necessary, including medical records, to secure payment.

Print Name _____**Signature**_____ **Date**_____

HIPAA Compliance

I hereby give consent to ***Orthomotion Inc.*** to use and disclose Protected Health Information (PHI) about me to carry out Treatment, Payment, and Health Care Operations (TPO).
I have read and understand the ***Orthomotion Inc.*** Notice of Privacy Practices. I understand that ***Orthomotion Inc*** may use or disclose my personal health information for the purposes of providing treatment, obtaining payment, internal assessment of quality of care provided, as well as for administrative purposes related to treatment or payment.
Orthomotion Inc. reserves the right to change the terms of our Notice of Privacy Practices at any time. A revised copy may be obtained upon request.
You have a right to request us to restrict how we use and disclose your PHI for the purposes of TPO. We are not required to grant your request, but if we do, the restriction will be binding on us.
You may revoke this consent in writing at any time except to the extent that the practice has already made disclosures in reliance upon your prior consent. If you choose not to sign this consent, or later revoke it, ***Orthomotion Inc.*** may decline to provide treatment to you and/or may be unable to accept any insurance as means of payment from you.

Print Name _____ **Signature**_____ **Date**_____

Print Name of Patient: _____
If you are signing as a patient's representative:

Please write your name _____ Your relationship _____

Indicate below the names of individuals whom ***Orthomotion Inc***. may speak to regarding your care:

Spouse _____ **Father** _____

Mother _____ **Other** _____

2995 Baseline Rd, Suite 304, Boulder, CO 80303 -Office Phone # 720 507 0643 – Fax 303 835 7171
info@orthomotion.net wwww.orthomotion.net