Healing Pathway

Holistic Physical Therapy and Bodywork

PERSONAL HEALTH INFORMATION

Your personal health information, which includes your entire medical history and information about services provided to you, is protected by law. This health record serves as a basis for planning your treatment, communication between your health care professionals, legal documentation, verification of treatment for third party payers, and a tool to improve your care based on outcomes. Although this record is the physical property of the health care provider, this information also belongs to you and you have rights regarding the privacy of your records. *A detailed explanation of these rights is available at our front desk and a copy is available to you upon request.*

In order to provide the best care possible, we may need to discuss your case with other health care professionals and health care facilities. *By signing below, I authorize* Holly Hamilton/ Healing Pathway to release my medical records to my physician and my other health care professionals. *I also authorize* Holly Hamilton/ Healing Pathway PT to request pertinent medical records from the professionals listed below (including related imaging) and share information back to them.

Please list pertinent health professionals and their contact information:

_____

_____

_____

I understand that my health information may include information both created and received by the clinic, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

By signing below, I agree that I have been informed about this privacy practice and my protected health information and how to obtain a personal copy of this form and privacy policy.

Signature _____ Date _____

CREDIT AND PAYMENT POLICIES

Our goal is to provide you with the highest quality care at a reasonable/reduced cost compared with many clinics. Your financial responsibility will be assessed and discussed at the time of your appointment and payment will be collected accordingly. Healing Pathway / Holly Hamilton are out-of-network for all insurance companies at this time. If you would like to personally submit a super-bill to try and get reimbursement from your insurance, you may let us know at your first visit.

All appointments will be paid in full at time of service. You may discuss setting up a payment plan if that is a need. Packages for follow-up visits are available at a reduced cost as well.

Signature _____ Date _____

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Patient Waiver: Print Name: _____

CONSENT TO TREAT

You are an important partner in your health care decisions and play an active role in the outcome of your medical care. Thus, it is important that you are informed about benefits, risks, evaluations, and decisions about your care while being seen at this office. If you have questions, symptoms, or problems related to your care it is your responsibility to notice your physical therapist and consult with your primary care provider as necessary.

By signing below, I agree to be treated by Healing Pathway Physical Therapy, knowing there may be potential risks along with benefits, and I am willing to be an active participant in my own care

Signature _____ Date _____

PATIENT MISSED APPOINTMENT POLICY

We are committed to fully assist you with your rehabilitation needs and thus, you are expected to attend all of your appointments. We are reserving this time specifically for You. If you need to cancel or reschedule an appointment, please do so a minimum of 24-hours prior to your appointment time. **A $50 fee will be charged for sessions missed without such prior notification.** *This fee will be due at or prior to your next treatment*. All cancellations and no shows are documented in your medical record. We understand there are occasional emergency situations and times of illness and we appreciate your consideration of our time. In instances of repeated non-compliance with scheduled visits, we reserve the right to discontinue care. By signing below, you agree to this policy.

Signature _____ Date _____