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 to you upon request.*

In order to provide the best care possible, Holly may need to discuss your case with other health care professionals and health care facilities. *By signing below, you authorize* Holly Hamilton / Healing Pathway to release your medical records to your other health care professionals. *You 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 any pertinent health professionals and their contact information if you would like us to collaborate on your behalf _____

_____

_____

You understand that your 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, you agree that you have been informed about this privacy practice and your protected health information and how to obtain a personal copy of this form and policy.

Signature _____ **Date** _____

CREDIT AND PAYMENT POLICIES

My goal is to provide you with the highest quality care at a reasonable cost compared with many PT 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 is in-network for a few insurance companies. If you wish for Holly to bill for you please confirm this prior to your session to verify benefits/coverage. Holly is out-of-network for most insurance companies, yet if you would like to personally submit a super-bill to try and get reimbursement from your insurance, you may let me know at your first visit. **All self-pay appointments will be paid in full at time of service.** You may discuss setting up a payment plan if that is a need.

Signature _____ **Date** _____

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Please review and complete 4 signatures below giving your agreement & consent

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, concerns or problems related to your care *it is your responsibility* to notify Holly and consult with your primary care provider as necessary.

By signing below, you agree to be treated by Healing Pathway, knowing there may be potential risks along with benefits, and you are willing to be an active participant in your own care.

Signature _____ **Date** _____

PATIENT MISSED APPOINTMENT POLICY

I am committed to assisting you with your rehabilitation needs and thus, you are expected to attend all of your appointments. I am 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 (unless you are ill on day of your appointment.) **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. I understand there are occasional emergency situations and times of illness and I appreciate your consideration of my time as well. In instances of repeated non-compliance with scheduled visits, I reserve the right to discontinue care.
By signing below, you agree to this policy.

Signature _____ **Date** _____