**Washington Health & Healing, LLC**
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Washington DC 20037
Voice: 202-223-4943 Fax: 202-223-4047
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## OFFICE POLICIES & AUTHORIZATION

**Welcome! Thank you for reading through this information carefully. It will answer some questions you may have. Please note- your signature is needed at the bottom of this page.**

SCHEDULING: Your appointment time is set aside specifically for you. If you are running more than 5-10 minutes late, please call to let me know. Missed appointments or ***appointments canceled less than 24 hours in advance are billed at the full cost of the office visit.*** Please note that email and voicemail are not checked after 5 p.m. weekdays, on holidays or weekends and that a phone message is best for last minute changes.

PAYMENT: Payment is due at the time of service. If you are coming 2-3 times per week, payment on a weekly basis is acceptable. Personal check, cash, Visa, and MasterCard are accepted. ***Please remember that part of your medical care is proper documentation; this means that a one hour appointment may include 45-50 minutes of treatment with time reserved to accomplish this task.

INSURANCE: In order to provide a high level of medical care, Washington Health & Healing, LLC does not participate with any insurance plans. You will receive a standard insurance receipt that has all necessary information should you wish to file with your insurance company for reimbursement. *Some health plans require pre-certification for physical therapy services. You are responsible for obtaining this authorization;* however, there may be forms for me to fill out and I am happy to do so. Washington Health & Healing, LLC is not enrolled in the Medicare program and therefore cannot submit payment for reimbursement. Please let me know if Medicare is your primary insurance.

REFERRAL/PRESCRIPTION: The law in Washington DC allows a physical therapist to evaluate and treat a person without a physician's referral or prescription. Your health insurance company may require a doctor's referral, so please check with your carrier.

ACKNOWLEDGMENT: I have read and understand the above policies and agree to, and abide by, all of these terms. I understand that payment is due at the time services are rendered. I also understand that I am personally responsible for all charges.

I, undersigned, grant consent for treatment and services provided by Washington Health & Healing, LLC.

| Name | Signature | Date |
|---|---|---|
| Legal Guardian (if applicable) | Signature | Date |