physiomobility HEALTH GROUP

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OFFICE & PAYMENT POLICY

It is Physiomobility's policy that payment for services is due in full by **Cash, Debit or Credit Card** at the end of each treatment session. A receipt with all of the required information will be provided to you so that you can submit it to your insurance company for re-imbursement. If you qualify for direct billing, you will only be required to pay any co-payments or deductibles not covered by your plan.

CANCELLATION POLICY

We require a **minimum of 24 hours' notice (48 hours' notice for Pelvic and Orthotics/Chiropody appointments)** for change or cancellation of any appointment. This will allow us to fill the available time slot with another patient who needs our services. The **FULL TREATMENT FEE** will be charged if you cancel the same day or if you do not show up for your appointment.

Compliance with your treatment plan designed by your therapist is an important factor in recovery. Patients who cancel frequently may be discharged for non-compliance.

Should you arrive late for your appointment or request to leave early, the full fee for the appointment time you have booked will also apply.

Please Note: We understand that your time is valuable and therefore make every effort to keep our schedule running on time. Due to the nature of our work, unexpected delays sometimes occur. Please be assured that under these circumstances you will still receive your full treatment time. Thank you for helping us to maintain a high level of service for all of our clients.

For your information, our payment processing system saves an encrypted version of the credit or debit card ,similar to the practice of many other clinics. This information is stored on the merchant processing system, not within our system. Only the last 4 digits of the card are visible to our staff. We do reserve the right to keep a credit card on file for the purpose of charging balances, no show fees or late cancellation fees.

I fully understand the above and agree to abide by these policies.

Patient's Name: _____

Patient/ Guardian's Signature (Printed name serves as signature): _____

Date: _____

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