Our Hands • Your Health
Innovations
REHABILITATION • S.C.
HEALING & WELLNESS CENTER

Please read and initial on each of the lines.

☒ _____**YOUR PRIVATE HEALTH INSURANCE** **Effective date: 5/01/2015**

Innovations will call on your healthcare benefits and will provide you with a print out of the details. This is not a guarantee of benefits. Benefits are determined at the time claims are processed. As a policy holder, spouse, or dependent, it is your responsibility to understand your covered and non-covered services. Innovations highly recommend that you call on your own benefits as well.

Any services not covered by your insurance, including deductible and co-insurance, will be billed to you monthly.

☒ _____**PAYMENT OPTIONS AND EXPECTATIONS** **Effective date: 05/01/2015**

The balance is due within 30 days, unless you have an approved payment plan. You may pay by Cash, Check or Credit Card. We accept Visa, MasterCard, Discover and American Express.

☐ _____**WORKERS COMPENSATION** **Effective date: 5/01/2015**

With your assistance, Innovations will gather information in regards to your WC claim.

Innovations will bill your WC insurance. If WC were to deny your claims, we will bill your private insurance. If you do not have private insurance you will be expected to pay the day of each visit with a 30% discount off our charges.

☐ _____**MOTOR VEHICLE ACCIDENT (MVA)** **Effective date: 5/01/2015**

With your assistance, Innovations will gather information in regards to your MVA claim. We will send claims to your MVA and your private insurance. Liability action against someone else is not a reason to delay payment. Payment of the bill is the responsibility of the individual who has received the treatment, not the individual who is being sued.

☒ _____**CANCELLATION AND NO SHOW POLICY** **Effective date: 5/01/2015**

We understand that unanticipated events happen occasionally in everyone's life. To be effective and fair to all patients, the following policies are honored: **24 hour** advanced notice is required when cancelling an appointment. This allows us to offer the appointment time to someone else as we have an extensive waiting list. If you are unable to give us 24 hours advanced notice, you will be charged **$65.00** for your appointment. This amount must be paid prior to your next scheduled appointment.

No Shows: Anyone who either forgets or consciously chooses to forgo their appointment for whatever reason will be considered a "no show". There will be a **$65.00** charge that must be paid prior to your next scheduled appointment. Late Arrivals If you arrive late, your session may be shortened in order to accommodate others whose appointments follow yours. Out of respect and consideration to your therapist and other patients, please plan accordingly and be on time.

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_____NOTICE OF PRIVACY PRACTICES

Effective date: 5/01/2015

We are required by law to protect the privacy of your health information, which includes information about your health history, symptoms, test results, diagnoses, treatment, claims and payment history (collectively, "Health Information"). We are also required to provide you with this Notice of Privacy Practices regarding our legal duties, policies and procedures to protect and maintain the privacy of your Health Information. We are required to follow the terms of the Notice of Privacy Practices unless (and until) it is revised. We reserve the right to change the terms of this Notice of Privacy Practices and to make the new notice provisions effective for the Health Information that we maintain and use, as well as for any Health Information that we may receive in the future. Should the terms of this Notice of Privacy Practices change, the revised Notice of Privacy Practices will be available at our office for individuals upon request, posted in a prominent location in our office, and placed on our web-site.

If you would like a copy of the Permitted Uses and Disclosures of Your Health Information, please request a copy.

If you have any questions or for additional information, please contact us at (608) 269-0555.

By signing below you acknowledge that you have read this form and are aware of all of its contents. You are also giving us permission to bill your insurance company(s).

Print Name: _____Signature: _____

Date: _____

**Innovations Rehabilitation has decided to keep in touch with our patients regarding any concerns or questions they have via email. We will also be implementing a monthly newsletter down the road which you can go to our website InnovationsRehab.com, to sign up for. If you are willing to give us your email please let either Debbie or Siri at the front desk. Thank you.

Email Address: _____