HARADA PHYSICAL THERAPY

Your Hometown Therapists

Cancellation/No Show Policy

Harada Physical Therapy reserves treatment times for your benefit. For us to best help you with your condition, it is important that you keep your scheduled appointments. It is not our intention to cause undue financial hardship for you as the patient, however, we cannot absorb a loss in revenue due to a lack of compliance. In addition, these fees are easily avoided by giving us advanced notice if you cannot come to your appointment.

Please initial in the blanks below to indicate you have read and understand our cancellation and no show fee policies.

_____ **Late Cancellation Fee $50.00:** Appointments cancelled **after 3:00 pm the business day PRIOR** to your appointment will result in a late cancellation fee. If we are able to reschedule you in the same week, we will waive this fee.

_____ No Show Fee $110: If you do not show up for your scheduled appointment and do not call to notify us of your absence, you will be charged a $110 no show fee.

_____ **All no show and cancellation fees are due at the time of your next scheduled visit.**

We reserve the right to cancel all future appointments after a patient accumulates more than three (3) late cancellations, no-shows, or combination of both.

Insurance Benefits

Our office makes every effort to be as accurate as possible when collecting your insurance information. However, you as the patient are responsible for your own insurance benefits and agree to the benefits given. If these benefits are not accurate, or you have changed your benefits, you are solely responsible for notifying us. You are agreeing to pay the balance not covered by your insurance upon receipt of your statement. If you have overpaid, you will receive a refund. Please direct any questions to your insurance company.

Authorization to Release Medical Information/Consent to Treat

I hereby assign all insurance benefits to which I am entitled to Harada Physical Therapy in the event they file insurance claims on my behalf. I hereby authorize Harada Physical Therapy to release all information necessary to secure the payment of said benefits. I realize they keep a record of the health care services provided to me and that I may see and obtain a copy of those records with the understanding that a fee may apply if copies are requested.

By signing below, I acknowledge that I have read and understand the information outlined above.

Patient signature: _____ Date: _____

Front Office Coordinator: _____ Date: _____

Oak Harbor
31955 SR20 Oak Harbor, WA 98277
P: 360-679-8600 F: 360-679-8554

Coupeville
101 S. Main St. Coupeville, WA 98239
P: 360-682-2770 F: 360-682-2959