## OFFICE POLICIES AND PROCEDURES

## APPOINTMENTS:

## Please be 5 – 10 minutes early and sign in for each of your appointments.

**Late arrivals exceeding scheduled time by greater than 15 minutes will be re-scheduled.**

Book your appointments at the beginning of each week for the following week.

Cancel your appointment if you are unable to attend, if you miss several appointments without reason, we may notify your physician and you may be discharged.

**Cancelled appointments or no show appointments, will result in a $50 dollar charge, if the clinic is not notified a minimum of 24 hrs prior.**

## Hours of Operation: Monday 8:00 AM-12:00 PM, Tuesdays 1:00 PM -5 PM, Wednesday – 2:30 PM – 6:00 PM, Thursday CLOSED, Fridays 1-6PM, Saturdays 8AM-2:00PM

## SAFETY:

Wear clothing that is appropriate for exercise & treatment.

Children must be under adult supervision and are not to play with any equipment be in treatment area.

Please notify the treating therapist of any changes in your condition or if you are unsure about a treatment.

Please call for assistance immediately if you are in any discomfort during your treatment.

**If you have inhalers or nitro spray, please have it with you at all times while in the clinic**

## PRIVATE PAYMENT:

A physician referral is recommended.  
Assessment fee is **$120.00 and is approximately 1 hour in length. One may or may not receive treatment on this day; treatment is dependent on how much is involved**. A Standard treatment (15 min of focused care) is **$80.** ½ hour (30 mins) of 1 on 1 treatment is **$160.** 1 hour one on one treatment is **$320.** Shockwave treatment sessions are $100.00 per session. Please speak to your provider to clarify which option is most beneficial for you.

**Payment must be provided per visit. Please ask the reception for payment methods**.

Once payment has been received, if you require, administration will print corresponding paid receipt for you to mail out and receive reimbursement directly from your insurance company.

**I have read and understand the above policies & procedures. I consent to the collection, use and disclosure of my personal information. The purpose of this collection is to provide assessment and treatment services relevant to my needs and to obtain information related to payment for services provided. The information collected may be disclosed to my referring or funding agency and discussed among my treatment team.**

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_