Our Policies

Instructions: Please read the policies and initial next to each statement.

_____**Patient Financial Responsibility** I agree to be responsible for all estimated deductibles, co-insurance, or co-payments. As in all health care situations, the guarantor is always responsible for payment. I understand that Wala'au Therapy, LLC. will contact my insurance carrier for estimated benefits and any requested payments will be the direct result of the verification. Therapy services may be put on hold or terminated if there is a problem regarding payment.

_____ **Change of Insurance** I agree to notify Wala'au Therapy, LLC. within 5 business days of any change of insurance. Change of insurance does not guarantee coverage of therapy services and failure to provide accurate insurance information in a timely manner will result in the unpaid insurance balance being transferred to patient responsibility.

_____ **Cancellation Policy** Wala'au Therapy, LLC. requires a 24-hour notice when you need to cancel an appointment. Any therapy session cancelled with less than 24 hours will be considered a "no show." If you fail to give this notice, we will charge you a missed appointment fee of $25. This charge is not covered by insurance and must be paid prior to the next scheduled appointment. Failure to make clear the missed appointment fee will result in the patient being put on hold. ***In order for you or your child to make optimal progress, it is important to attend all scheduled therapy sessions. Excessive missed appointments, cancellations, or three "no shows" will result in immediate discontinuation of services.**

_____ **Sick Policy** The Board of Health considers the following signs to indicate communicable disease/ illness: vomiting, fever over 100 degrees, diarrhea, sore throat, rash/swelling, red or running eyes. Please be sure you or your child is symptom free for 24 hours before resuming therapy.

_____ **Email & Text Policy** Wala'au Therapy, LLC. will always communicate with you or your family in the most personally convenient way possible. Our office uses email and text messaging to communicate about things such as appointments, schedules, or billing. Your private electronic health information will not be included in any email or telephone conversation. Please indicate your communication preferences below:

_____Yes, please communicate with me via email and/or text messaging.

_____No, please do not communicate with me via email and text messaging. I understand that I will only be able to make and receive phone calls.

_____ _____ _____

Name of person completing form Signature Date