Policies & Procedures

Thank you for choosing Patricia Fasciotti Wellness, LLC. This is an agreement between Patricia Fasciotti Wellness, LLC and you regarding our policies.

Consent to Treatment

I authorize Patricia Fasciotti Wellness, LLC to provide physical therapy evaluation and treatment. Skilled treatment may include manual therapy, including deep tissue massage, myofascial release, and joint mobilization, in addition to therapeutic exercise and neuromuscular re-education. The number of treatments needed and recovery time can vary widely due to a number of factors. No guarantees have been made to me about the outcome of therapy. I have read and fully understand the above statements. I understand the nature of the treatments from Patricia Fasciotti Wellness, LLC, and I authorize the fully trained staff to use treatment techniques as deemed necessary for my safe and effective recovery. _____ (initial here)

Charge for Services

You agree to be financially responsible for all charges regardless of any applicable insurance or benefit payments, third-party interest, or the resolution of any legal action or lawsuits in which you may be involved. Patricia Fasciotti Wellness, LLC is a fee-for-service provider; we are not "in-network" with any insurance companies and do not bill insurance. _____ (initial here)

Payment Policies

Payment is due at the time of service. You may elect to use FSA/HSA funds, credit card, check, or electronic payment such as Apple pay/Venmo. _____ (initial here) I acknowledge that I am aware that submitting an itemized receipt to my insurance company does not guarantee reimbursement, and I am solely responsible for payment of my bill. _____ (initial here)

Privacy

All therapy sessions, diagnoses, and family history information will be kept confidential. You have a right to privacy under the Health Insurance Portability and Accountability Act (HIPAA) that includes restricting disclosure of your records and claims to your health plan, including Medicare, if you pay privately for your services at the time of service. By paying for your services at the time of service, we assume you are exercising this right to privacy and we will not disclose your medical records to any third party, including your health insurance carrier or Medicare. I acknowledge that, although safeguards are taken to protect my/my child's confidentiality, there is no absolute guarantee of confidentiality when using electronic/digital communication. _____ (initial here)

Cancellation & Attendance Policy

As a courtesy to our therapists and clients, we require a 24-hour notice for cancellation to avoid full charge for missed services. Appointments must be rescheduled within the same week to avoid charges. I UNDERSTAND THAT MISSED APPOINTMENTS THAT ARE NOT CANCELLED 24 HOURS IN ADVANCE WILL BE CHARGED AT THE FULL FEE. THESE MISSED APPOINTMENTS CANNOT BE PAID WITH HSA/FSA FUNDS OR FILED FOR REIMBURSEMENT AND I WILL BE HELD FINANCIALLY RESPONSIBLE. _____ (initial here)

Discontinuation Policy

Termination of therapy and wellness services is voluntary at any time.

I have read, understand, and agree to abide by the aforementioned policies.

Signature: _____ Date: _____, 2020

UPDATED SEPTEMBER 2020