pilates in the grove

Practice Policies- Please Read, Initial and Sign where needed

New Patients

For new patients: If you do not have the forms filled out prior to your first visit, please come 15 minutes early so that they can be completed before your scheduled appointment time. A valid credit card number must be provided when scheduling your first appointment and will be charged a cancellation fee if you do not cancel within 12 business hours(8am-7pm) of your appointment time. This card number is securely protected in your electronic medical record and is only used if you should miss an appointment in the future without 12-hour cancellation (8am-7pm). _____

Returning Patients

For returning patients, please bring your new prescription if you were referred and any updated intake forms and Patient Insurance Worksheet if any content has changed.

Fees/Payment

Payment is due in full at the time of each session. We accept cash, check and credit cards. _____

Insurance Reimbursement

Pilates in the Grove LLC is not a preferred provider with any insurance plan. We can provide an invoice to you at each visit for you to submit to your insurance company if you have out of network benefits and choose to submit for reimbursement. We suggest that you contact your health insurance company before your first visit and use our Patient Insurance Worksheet to get the information you need to maximize your out-of- network benefits. The worksheet is provided to help you ask the right questions. It is your responsibility to understand your health insurance coverage, know how to get reimbursed and at what level. It is your responsibility to follow-up with your insurance company after the submission of claims to ensure that the claims are processed correctly. If Medicare is your insurance provider we will be happy to recommend clinics that are covered. We do not participate with Medicare for physical therapy however Medicare clients can be seen for Wellness/Pilates. Your signature below indicates you are financially responsible for all charges incurred and that outstanding balances over 90 days can be processed by a collection agency.

Signature: _____ Date: _____

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5900 SW 73rd Street, Suite #104, South Miami, FL 33143 • (305) 397-8308

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All Services listed under Therapeutic Massage and Alignment, Myofascial Release, Wellness and Pilates are not covered by insurance and are paid in full at the time of each session. By initialing here you are acknowledging that these services are offered as part of a maintenance recovery program and do not qualify for insurance reimbursement. _____

Prescription/Physician Referral

Even though the state of Florida has direct access to physical therapy, the number of sessions that is allowed without a prescription is unlimited for 30 consecutive days following your initial examination. If you require treatment beyond 30 days you will be required to obtain a valid prescription from a licensed physician. Additionally, your insurance company may require a prescription before they provide coverage. You will then need to obtain an updated prescription every 10 visits. _____

Treatment Sessions

A session typically lasts for 55 min. For your evaluation and each follow up visit, please wear or bring clothes that are appropriate for exercise and that allow us to treat at and around the affected area. (Such as shorts, yoga pants or sweat pants and tee-shirt or tank top). _____

Consent To Treat

The patient hereby consents to the administration of appropriate evaluation and therapeutic procedures as requested by the physician prescribing care and/or via direct access and subsequent approval of the patients primary care provider. The therapist will monitor your progress and adjust treatment frequency and duration according to medical necessity as needed. _____

Medical Information/Medical Records

We understand that your present and past medical information is personal. We are committed to protecting information about you. We create a record of care and services you receive at Pilates in the Grove LLC that is maintained electronically. This allows for us to remain free of paper charts, that are prone to damage, loss, or security concerns. We need these records to provide you with quality care, to comply with legal requirements and to meet your needs for reimbursement. This notice applies to all of the records generated: law to requires us:

a) Make sure that medical information that identifies you is kept secure.

b) Give you this notice of our legal duties and privacy practices with respect to medical information about you.

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c) Please make sure you have completed your intake forms fully to ensure that your medical record is complete.

Newsletter and Contact:

If you supplied an email address, you will be signed up for our email newsletter. This will include updates, news, classes, deals, presentations and the like. If you do not wish to receive these, please initial here _____

Tardiness

We ask that you arrive on time for your appointments and that you are considerate of the next patient's time when your session ends. If you arrive late your treatment time will be shortened. _____

Cancellations/No Shows

Please give us 12 hours notice if you are unable to keep your appointment. Cancellations should be made by calling, emailing or texting the office during our normal business hours (8am-7pm Mon-Thurs and 8am-3pm Fri). Failure to give 12 hours notice will result in a $55.00 charge to your credit card or account. No-shows and cancellations with less than 1-hour notice will result in the full fee of the session. By signing below, I certify that I have read the above policies, understand and will comply with them. I agree that Pilates in the Grove LLC retains the right to charge my credit card for scheduled appointments missed by lateness, late cancellations or no show activity, as described above. _____

Signature of Patient or Guardian:

_____

Print name:_____ Date:_____

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Name: _____ Date of Birth: _____

Do you have a valid prescription for treatment: Y N

Referring Physician: _____

Do you plan to seek reimbursement for services?: Y N

Insurance Provider:_____

Reason for Visit:_____

Previous Surgeries:_____

Have you been previously treated for this injury ?: _____

Goals for Therapy:

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