

OFFICE POLICIES

OCEAN THERAPY CENTER, INC
4001 N. Ocean Drive, Suite 302
Lauderdale-By-The-Sea, Fl 33308
(954) 351-2299 • Fax: (954) 351-3399

We at Ocean Therapy Center Inc. are committed to providing you with the best possible care. To make this possible we adhere to a set of very important policies. Your clear understanding of our policies is important to our professional relationship. Please read them carefully and indicate your agreement by signing at the bottom. Please ask our staff if you have any questions.

SCHEDULING

Office hours are by appointment only. We appreciate your personal schedule and will make every effort to accommodate your special scheduling needs. If you will be early or late for your scheduled appointment, please notify us to schedule accordingly. Being late by more than 15 minutes may require you to reschedule your appointment. We require 24 hours notice in the event of cancellation. There is a \$15 service fee for cancellations or no-shows without proper notice. This charge will not be covered by your insurance.

FINANCIAL AGREEMENT

Payment is due for services at the time services are rendered. All co-insurance, co-payments, and deductibles are due as services are provided. We submit all billing to insurance companies as a courtesy to our patients; however, it is your responsibility to know the details of your coverage which may determine the extent of your financial responsibility. Once your insurance has been billed, we require balance not covered by insurance to be paid within 30 days. Co-payments and non-covered services are to be paid at time of each visit. Late cancellations/no-shows service fee are to be paid prior to your next visit. This is a \$15 charge. If you should choose to suspend or terminate your care and treatment, any outstanding fees for professional services will be immediately due and payable.

CONSENT TO PHYSICAL/OCCUPATIONAL THERAPY

TREATMENT/AUTHORIZATION TO PAY AND RELEASE INFORMATION:

I authorize Ocean Therapy Center, Inc. to make inquiries as it determines necessary to confirm my coverage and my financial responsibility. I authorize payers and/or references to release such information to Ocean Therapy Center, Inc. I further understand that in signing as a patient or agent, I obligate myself to pay for services rendered. I agree to pay for services denied or not covered by my insurance regardless of the reason for non-payment. A photocopy of this document is to be considered as valid as an original. I hereby assign Ocean Therapy Center, Inc. all payments to which I am entitled for expenses related to services performed and direct payment for such services be made to Ocean Therapy Center, Inc.

I have been given the Notice of Patients' Rights and I consent to physical/occupational therapy treatment.

I have carefully read and agree to all the above policies. In the event such policies are broken, I agree to the consequences set forth.

Signature (Parent or guardian signature if patient is a minor)

Date

Patient Name