1917 Fir St, Port Townsend, WA 98368

tel. 206.860.3746

info@sanctuaryforphysicalarts.com

Welcome!

Your Treatment Plan: This plan is based on your goals, medical needs, and physical evaluation.

- *I agree and give my consent for Sanctuary for Physical Arts (SPA) to furnish care and treatment considered necessary and proper in diagnosing or treating my physical condition.*

Signature: _____ **Date:** _____
(Parent/Guardian if patient is a minor)

➔**Privacy Practices:** *I have been offered a copy of SPA's Notice of Privacy Practices.*

Cancellation Policy: Your appointment time is reserved for you. Please contact us by phone as soon as possible if you are unable to keep your appointment, so that we may offer your time to someone else. Kindly give 24-hour notice for any cancellations to avoid a full appointment charge.

Financial Policy: We do not bill any insurance company, except auto insurance personal injury protection (PIP/MedPay) claims. However, we are happy to provide the information you need to file your claim directly with your insurance plan for reimbursement. Payment is due at time of service. We accept cash, checks, credit card, and Paypal payments. In the unusual situation where there is an unpaid balance, there is a $5 statement fee and a service charge of 0.75% per month may be added to any account balance over 60 days past due. Returned checks result in a $35 fee.

Release of Information/Financial Responsibility: We do not bill any insurance company, except PIP/MedPay. You are ultimately responsible for payment and for knowing what is covered or not covered by your insurance plan.

- I authorize the release of any information necessary to process claims.
- I agree that I am financially responsible for any balance due on all covered or non-covered services.
- I understand that I will be charged the full appointment fee if I cancel without notice.
- I understand that payment is due at time of service. I am aware past due accounts will be subject to a $5 statement charge, plus a charge of 0.75 % per month and that returned checks will result in a $35 fee. I am responsible for all collection costs incurred by Sanctuary for Physical Arts should my account remain unpaid. I have read the complete SPA Financial Policy.

Signature: _____ **Date:** _____
(Parent/Guardian if patient is a minor)