phone: (509) 350-2506
email: cdotson@OYHPT.com
website: www.OYHPT.com

Cancellation & No-Show Policy

Thank you for choosing Own Your Health Physiotherapy to help you own your health. We look forward to helping you identify and achieve your specific goals. By saying yes to you, we are saying no to other people who would benefit from our services. Because of this and because we believe following your unique plan of care is critical to achieving your goals as efficiently as possible, we request you review and agree to the following policy.

Should you need to change your appointment, Own Your Health Physiotherapy requires you to notify us at least 24-hours prior to your scheduled appointment time. Your timely call allows us to more effectively manage our schedule, ensuring we provide the best possible care to the maximum number of people.

Should you fail to provide sufficient notice, we reserve the right to charge you a $100 fee. For the sake of our other clients, multiple no-shows and/or late cancellations will result in requiring same-day scheduling and/or the need to find a different provider to help you achieve your goals. If you are an injured worker, we are required to notify your primary care provider and claims manager after two cancellations and/or no-shows.

Also, if you are running late, the missed time will need to be subtracted from the total treatment time. Furthermore, we may or may not be able to extend treatment beyond your scheduled session time.

Communication Release

I give Own Your Health Physiotherapy permission to communicate with me via the following methods regarding health information, medical records, offers and other related correspondence using the information provided on my Client Information Sheet. I recognize that such communications may not be secure and accept any inherent risks in such communications.

Consent for Treatment/Financial Responsibility

I hereby consent to treatment at Own Your Health Physiotherapy as deemed advisable by myself, my Own Your Health Physiotherapy provider and/or my referring provider. I further attest that I am not a recipient of Medicare benefits and am in no way insured by or under Medicare. Should this status change

I understand a $25 processing fee will be added to all returned checks. I agree to be responsible for all charges for services rendered regardless of litigation or insurance reimbursement. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account. I understand that unpaid accounts past 90 days may be sent to a 3rd party collection agency.

By signing below, I acknowledge awareness, understanding and agreement with all policies stated above and authorize treatment from Own Your Health Physiotherapy. I also attest to having read and understood Own Your Health Physiotherapy's Notice of Privacy Practices.

Signature of Patient or Legal Guardian:_____ Date:_____