



TO VITAL ENERGY OCCUPATIONAL THERAPY & WELLNESS CENTER  
PATIENTS:

All of us at Vital Energy Occupational Therapy & Wellness Center wish to thank you for choosing our clinic for your therapy needs. In order to better serve our patients, and to keep our charges to a minimum, we would like to advise you of our clinic policies as follows:

**1) CO-PAYMENTS & DEDUCTIBLES MUST BE PAID AT TIME OF SERVICE.** Our contracts with various insurance companies require that we collect deductibles and patient co-pays at the time of service. We are in violation of our contract if we fail to do so. We verify your remaining deductibles and coverage with your insurance company at your first visit. The contracts require that we base our deductible charges and collect estimated co-pays based upon this information until we receive an Explanation of Benefit (EOB) and first payment from your insurance company (usually 4-6 wks after date of service). After we receive the first EOB, we adjust your deductible according to the information shown there. Your insurance policy dictates what **we must collect** at each visit.

Beginning Jan. 2006, we have asked patients to pay appropriate deductibles and co-payments with each visit. **Please be reminded that we do not accept credit or debit cards. We require cash or check only.** Parents of students coming alone for treatments may make arrangements to pay weekly. We will make every effort to provide you with an agreeable payment plan, if needed; but if your account is turned over to your collection agency, you are responsible for an **additional 30% collection fee.** Because of lack of privacy, we ask that you **do not call the clinic to discuss financial issues.**

**2) CANCELLATION NOTICE: We require a minimum of 12 hrs. for cancellation or we reserve the right to charge \$30 for the missed appointment.** If this is impossible, please be courteous and give us as much advance notice as possible to enable us to contact other patients who might need this time. Parents, please advise student patients of this policy and follow up to make sure that they keep appointments.

Thank you once again for your patronage and cooperation with our policies.

\_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_  
Patient or Responsible Party Signature      Witness