**HEALTHY LYMPHATICS OF NC, PC**

**Phone: 828-355-9584**

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**Healthy Lymphatics-Boone office Healthy Lymphatics-Elkin office Healthy Lymphatics-Mt. Airy office**

**450 New Market Blvd Ste 3 2015 North Bridge St 905 Rockford St**

**Boone, NC 28607 Elkin, NC 28621 Mount Airy, NC 27030**

 **Healthy Lymphatics-North Wilkesboro office Healthy Lymphatics-Galax VA office**

 **1912 West Park Drive 812 West Stuart Drive**

 **North Wilkesboro, NC 28659 Galax, VA 24333**

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| **We feel that everyone benefits when there is a definite and clear understanding of our policy here at HEALTHY LYMPHATICS OF NC, PC prior to treatment. Therefore, we ask you to INITIAL next to what you understand. If you do not understand or have any concerns, please feel free to ask.** |
|  **\_\_\_\_\_\_\_\_\_\_** | **I understand that I am fully responsible for any non-covered services or materials including returning all bandages used during my treatment.** |
|  **\_\_\_\_\_\_\_\_\_\_**  | **I understand that my payment is due and payable at the time of service.** |
|  **\_\_\_\_\_\_\_\_\_\_** | **I understand that it is my responsibility to pay any outstanding balance if my insurance company should delay payment for any reason beyond 60 days after services are rendered.** |
|  **\_\_\_\_\_\_\_\_\_\_** | **I understand that if I am unable to pay my entire balance after 60 days, I agree to make payments at no less than 20% of the outstanding balance on a monthly basis.** |
|  **\_\_\_\_\_\_\_\_\_\_** | **I understand that an annual finance charge of 25% will be imposed on my account which has not been paid off within 60 days of the account past due.** |
|  **\_\_\_\_\_\_\_\_\_\_** | **I understand that if no payment or arrangements are made to pay off my balance after two written collection fees my account may be submitted to a collection agency.** |
|  **\_\_\_\_\_\_\_\_\_\_** | **I understand that there will be a $30 service charge on all returned checks.** |
|  **\_\_\_\_\_\_\_\_\_\_** | **I understand that there will be a $30 service charge for missed appointments or for appointments cancelled with less than 24-hour notice.** |
|  **\_\_\_\_\_\_\_\_\_\_** | **I understand that HEALTHY LYMPHATICS OF NC, PC may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment from insurance companies, evaluating, the quality of services provided and any other administrative operations related to treatment or payment.** |
|  **\_\_\_\_\_\_\_\_\_\_** | **I understand that I am voluntarily giving consent for me or my minor child whose name appears on the patient registration form to receive therapy.** |
|  **\_\_\_\_\_\_\_\_\_\_** | **I understand that I am giving consent to receive therapy to include evaluation/examination and specific treatment procedure deemed necessary to improve my condition.** |
|  **\_\_\_\_\_\_\_\_\_\_** | **I understand I can refuse treatment anytime.** |
|  **\_\_\_\_\_\_\_\_\_\_** | **I understand that no guarantees have been made as to the outcome of my treatment.** |
|  **\_\_\_\_\_\_\_\_\_\_** | **As a courtesy, HEALTHY LYMPHATICS OF NC, PC will obtain a quote of benefits for their patients. This quote is not a guarantee of payment by your insurance company.** |
|  **\_\_\_\_\_\_\_\_\_\_** | **I understand that at some point during my treatment I may be photographed to be used as a “before and after” comparison.** |