

YamaPT Clinic Policies/Rates and Insurance Guidelines

The rates for Initial Evaluations are, \$150 for a 60 minute session, followed by \$100 per treatment sessions for 50-55 minutes (during normal business hours.)

YamaPT is a fee-for-service provider; payments are due in full at each session. Your insurance company will NOT be billed; however, you may send self claims to insurance for reimbursement at an out-of-network rate, if desired. Receipts with diagnosis and treatment codes will be provided per request. In the event your insurance company reimburses YamaPT, the reimbursement will be returned to the insurance company and a new check must be written to you personally. Cash, personal checks, and credit cards are accepted for payment.

Additionally, YamaPT is NOT a Medicare provider. Medicare will NOT pay for services at YamaPT as we are NOT a participating provider with Medicare or any other insurance company. You will NOT be able to submit reimbursement for services as they do not meet the rules set by Medicare regulations. Therefore, any receipts you may request will not include diagnosis codes and other information that Medicare claims usually possess.

As a courtesy to other patients trying to schedule appointments and the therapist's work schedule, a 24 hour or greater cancellation notice is required. This allows others on waiting lists to be seen. Only emergencies and illnesses are excusable. You will be billed 50% of the entire appointment fee upon violation of this policy.

YamaPT will maintain your privacy to the highest standards and may use or disclose personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I have read and fully understand the above statements. I understand the nature of the treatments at YamaPT, LLC. I authorize Tyler Yamauchi PT, DPT to use treatment techniques as deemed necessary for my safe and effective recovery.

I HAVE READ AND COMPLETELY UNDERSTAND THE ABOVE WRITTEN STATEMENTS

X _____ Date _____
Signature of patient/legal guardian

I ALSO UNDERSTAND THAT MEDICARE WILL NOT REIMBURSE FOR SERVICES RENDERED BY YAMAPT, LLC.

X _____ Date _____
Signature of patient/legal guardian