# **INMOTION HEALTH, PA**

Patient Financial Consent Form

The following document serves to create an understanding between **INMOTION HEALTH, PA** (“Provider”) and **Patient** regarding Provider’s financial policy, as it relates to services rendered by its physicians and affiliated healthcare providers. If there are any questions regarding this Financial Policy, please contact our office directly at (954) 228-3019 or email us at [contact@inmotionhlth.com](mailto:contact@inmotionhlth.com) to speak with our billing department.

1. Payment for services rendered is due at the time of service, unless other arrangements have been made prior to the visit.
2. Provider accepts the following methods of payment: American Express, MasterCard, Visa, Discover or debit card.
3. Provider does not accept any form of insurance. Provider will not be responsible for contacting Patient’s insurance company for reimbursement, but will provide documentation to Patient, within a reasonable time period, upon written request from Patient. Claims to Patient’s insurance company may be made by Patient for reimbursement of Provider’s services provided by an “out-of-network” provider.
4. Provider will make all reasonable efforts to change or reschedule an appointment. However, a cancellation fee will be charged if the appointment is canceled with less than two (24) hours notice to Provider from the scheduled appointment time with Provider. To cancel an appointment, the Patient must notify the Provider by either emailing the practice, calling the practice or using the patient portal. Cancellation requests will only be considered valid once acknowledged by the Provider or a member of the practice staff. Cancellation fee will be equal to 50% (fifty percent) of the normal, predetermined service visit fee, in effect as of the day of the appointment. If the appointment is rescheduled for the same day as the original appointment, n cancellation fee will apply.

I have received a copy, read, understand and agree to this Patient Financial Policy. I agree to be legally bound by its terms. Terms contained herein may be amended by Provider and will be provided to Patient prior to the Provider providing any services to Patient.

Signature of Patient/Authorized Representative Date

Name of Patient/Authorized Representative (Print) Relationship to Patient