

## **Yoga for Healing, PLLC.**

**Tanya Penny OTR/L**

Occupational Therapist, Level II iRest, RYT 200

3072 S. Cadet Lane, Boise, ID 83706

Phone (208) 629-6615 Fax (208) 246-5353

### **Financial Policy 2011**

To provide you with the best care and service possible a clear understanding of the Financial Policy is important to our professional relationship. Tanya Penny, OTR/L is serving you on a “Cash-Only” basis (**Checks, MC/Visa, Money Orders, and Cash are accepted**). *If you would like to use your insurance please read the “Insurance Information” form. Many insurance plans are accepted. Your insurance reimbursement: If you are using health insurance benefits, it is your responsibility to be aware of your policy & its benefits and limitations. All policies are different. Please come prepared to make your session payment (or co-pay if you have in-network insurance) at the end of each office visit.*

Payment for your treatment sessions are due in full at time of service until insurance coverage is confirmed or unless payment arrangements have been made in advance. Positive balances are applied to future co-payments or refunded. All charges are billed according to time spent in a session as outlined below.

#### **INITIAL INTAKE SESSION \$120-\$150.00 (60-75 minutes)**

The session includes an initial consultation, assessment/interview. This is also an active therapeutic session including iRest/Viniyoga education, discussion, and recommendations for home practice/program.

#### **FOLLOW-UP SESSIONS \$90-120.00 (60 minutes)**

Return session and/or series of sessions include follow-up, education/training in iRest/Viniyoga, discussion, recommendations for home practice/program. Include self-practice CD's for iRest.

#### **PHONE CONSULTATION \$90 (60 minutes).**

Phone consultations are available for iRest only. Insurance is not accepted for phone sessions.

#### **EXTRA TIME \$15-30.00 (per 15 minute)**

If more time is needed and available.

\*Packages expire four (4) months from the date of purchase.

**CANCELLATION/LATE FEES:** A LATE CANCELLATION FEE OF \$90.00 WILL BE CHARGED FOR SESSIONS MISSED WITHOUT 24 –HOUR NOTICE. Insurance companies do not cover missed appointments.

**I have read, understand and agree to the above information.**

Client's Name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature of parent, guardian, or responsible party

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**PAYMENT PLAN**

\_\_\_\_\_ I agree to pay the session fee or insurance co-pay in full at the time of service.  
(cash, check, Visa or Master card)

\_\_\_\_\_ I request that my credit card be charged for each session fee or insurance  
co-pay at the time of service.

\_\_\_\_\_ I agree that my credit card be charged for cancellation/late fees.

\_\_\_\_\_ I request that my credit card be charged monthly for session fees or insurance co-pays.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**CREDIT CARD INFORMATION**

**I authorize Yoga for Healing, PLLC. to charge this account for services according to the financial policies and payment plan checked above.**

TYPE OF CARD: VISA MASTERCARD DEBIT Account Number: \_\_\_\_\_

EXP. DATE: \_\_\_\_\_ SECURITY CODE \_\_\_\_\_

BILLING ADDRESS: \_\_\_\_\_ BILLING ZIP CODE: \_\_\_\_\_

Name of card holder: \_\_\_\_\_ Signature: \_\_\_\_\_

**INSURANCE INFORMATION – Please provide a copy of your insurance card (s), front & back**

Patient’s Relationship to Insured: ( ) self ( ) spouse ( ) child ( ) other \_\_\_\_\_

**Patient DOB:** \_\_\_\_\_ **Patient SSN#:** \_\_\_\_\_

**Primary insurance carrier:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

Name of insured: \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Insured ID number: \_\_\_\_\_ Group number: \_\_\_\_\_ SS# \_\_\_\_\_

Insured date of birth: \_\_\_\_\_ Phone: \_\_\_\_\_ Employer: \_\_\_\_\_

Insured’s address: \_\_\_\_\_

**Secondary Insurance Carrier:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

Claims address: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Insured ID number: \_\_\_\_\_ Group number: \_\_\_\_\_ Date of birth: \_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Signature of parent, guardian, or responsible party