Longevity
Brain & Body
Wellness, LLC

NOTICE OF PAYMENT POLICY

By providing my signature below, I acknowledge that Longevity Brain and Body Wellness, LLC does not negotiate directly with third party payer sources. Payment for services is due in full via our website at the time of scheduling of a service. I understand that I may request a receipt for services should I choose to submit to my insurance company on my behalf. I acknowledge that Longevity Brain and Body Wellness, LLC is not able to provide therapy services to persons with Medicare insurance at this time, however wellness and preventive services may be provided. I have notified Longevity Brain and Body Wellness, LLC if I have Medicare insurance.

_____ (Client Signature) _____ (Date)

_____(Witness Signature) _____ (Date)

ATTENDANCE AGREEMENT/CANCELLATION POLICY

I understand that my attendance is required to achieve maximize benefit from my therapy and/or wellness services. At least 24 hours advanced notice is required for cancellation prior to an existing appointment. I acknowledge that I may be charged in full for a cancelled appointment with less than 24 hours advance notice. I understand that cancellation of three visits in a row may result in discussion with my therapist regarding discharge from services.

_____ (Client Signature) _____ (Date)

_____(Witness Signature) _____ (Date)

AUTHORIZATION TO EXCHANGE, OBTAIN, OR RELEASE INFORMATION

If receiving speech or physical therapy services, Ohio State Practice Acts require notification of your physician of therapy services within five business days of initial evaluation. If condition is not improving or worsening, we are required to refer you back to your physician after 30 days if not sooner. If we deem your condition outside of our respective scope of practice or identify a red flag requiring medical care beyond our services, we are required to refer you back to your physician and therefore it may be necessary to notify your physician and/or contact your physician's office.

By signing below, I authorize members of Longevity Brain and Body Wellness, LLC to contact my physician's office. I have provided accurate contact information for my physician on the Client Intake Form.

_____ (Client Signature) _____ (Date)

_____(Witness Signature) _____ (Date)

RIGHT TO WITHHOLD SERVICES

Longevity Brain and Body Wellness, LLC provides in-home services to our clients in the following suburbs: Avon, Avon Lake, Bay Village, North Olmsted, Olmsted Falls, Rocky River, Westlake. We reserve the right to decline services if a location is outside of our window of operation or a service location is deemed to have unfit conditions to safely provide our services. We reserve the right to cancel appointments in the case of adverse weather conditions or extenuating circumstances, however will make reasonable attempt to reschedule appointments in a timely manner and notify clients as soon as possible in the event of cancellation.

By signing below, I acknowledge notification of the above policy.

_____ (Client Signature) _____ (Date)

_____(Witness Signature) _____ (Date)