Office Policies

A. **Cancellation/Missed Appointment Policy**

I require 24 hours notice for cancelled appointments. Any cancellation with less than 24 hours notice or a missed appointment will be subject to a $35 fee.

Please initial here _________to confirm that you understand and agree to honor this policy.

B. **Payment Method**

I accept payment by cash or check. There is a $20.00 fee for a bounced check and only one occurrence is permitted. If a second check bounces, I will accept cash-only payment from then on.

C. **Electronic Communications Consent**

Our preferred way of communicating with you is by telephone. There may be occasions where you may need to communicate with Flojo Therapeutic Massage by email or through text messaging. Due to the HIPPA Privacy and Security Rules we need to obtain your permission to communicate with you through email/texting.

I confirm that I wish to communicate with Flojo Therapeutic Massage by email/text messaging and I understand that:

- Email/Text communication will be considered and treated with the same degree of privacy and confidentiality as written medical records.

- Standard email communication services, such as AOL, Yahoo and Hot Mail are not secure. This means that the email messages are not encrypted and can be potentially intercepted and read by unauthorized individuals.

- Your email address will not be used for external marketing purposes without your permission. You may receive occasional group emailing from Flojo

Therapeutic Massage, however, the recipients email addresses will be hidden.

- Text Messaging is not a totally secure system for sending and receiving information.

I have read and understood the above description of the risks and responsibilities associated with electronic communication with Flojo Therapeutic Massage.

I acknowledge that commonly used email services are not secure and fall outside of the security requirements set forth by the Health Insurance Portability and Accountability Act for the transmission of protected health information. I have been given the opportunity to discuss electronic communication with Flojo Therapeutic Massage and have had all my questions answered. In consideration for my desire to use electronic communication as an adjunct to in-person office visits, I herby consent to electronic communication via non-secure email services and text messaging. I understand that I may revoke my consent to communicate electronically at any time by notifying the practice in writing at the address above, but if I do, the revocation will not have an affect on actions my healthcare provider or team has already taken in reliance on my consent.

I agree and release Flojo Therapeutic Massage from any and all liability that may occur due to electronic communication over a non-secure network. I further agree to be held accountable and to comply with the patient responsibilities as outlined in this consent.

PATIENT

____
Patient Authorized Email Address (please print)

____
Patient Name (Print)

____
Patient Signature Date