Ayurbliss, LLC
Integrative Physical Therapy

FINANCIAL POLICY AND PATIENT CONTRACT

Ayurbliss, LLC is an "out of network" provider for most Insurance except UHC. We will bill your health insurance company for the physical therapy services rendered to you if you are in network. For out of network patients we will provide you with an invoice to file you Insurance Claim. All charges for services rendered are your responsibility from the date of service. Please call your Insurance to verify coverage, Physical Therapy benefits and limitations. Your insurance policy may provide payment that is less than our customary fee. Payment may be made by cash, check, MasterCard or Visa. This document is a contract between you and Ayurbliss, LLC.

CANCELLATION POLICY: A minimum of twenty-four (24) hour notice to cancel or reschedule an appointment is required. A $50.00 charge may apply if proper notice is not given. This charge will not be paid by any insurance carrier.

INTEREST CHARGES: Services paid for in full within ninety (90) days of the service date are not subject to any interest charge. An interest charge of 1.5% per month (18% per annum) will be charged on all balances unpaid after ninety (90) days.

COLLECTIONS: Ayurbliss, LLC has the right to use legal action, including but not limited, to small claims court to assist in collecting any past due balance. Should Ayurbliss, LLC seek legal action any reasonable attorney costs will be your responsibility.

I understand and agree, regardless of my insurance status, that I am ultimately responsible for the payment of services provided to me by Ayurbliss, LLC.

PRINT YOUR FULL NAME:_____

PRINT PATIENT'S FULL NAME (If Different)_____

SIGNATURE: _____DATE:_____

ASSIGNMENT AND RELEASE OF INSURANCE BENEFITS

I hereby authorize my insurance benefits, of any kind, to be paid directly to Ayurbliss, LLC. I further authorize Ayurbliss, LLC, to release my medical records or information to any insurance company, as necessary or required to process my insurance claims.

PRINT YOUR FULL NAME:_____

PRINT PATIENT'S FULL NAME (If Different)_____

SIGNATURE:_____DATE:_____

Dr. Rucha Kelkar, BAMS, PT, DPT
Licensed Physical Therapist
Ayurvedic Doctor
Yoga Therapist

www.ayurbliss.com
info@ayurbliss.com
407 N San Mateo Drive, San Mateo, CA 94401
Tel (949) 293- 2950 Fax (650) 523-4497