# Southwest Therapy & Rehab LLC

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## FINANCIAL POLICY/DISCLOSURE STATEMENT

Thank you for choosing SW Therapy and Rehabilitation for kinesiology. The following is a statement of our financial policy and disclosure statement. **Please initial after you have read each statement and sign at the bottom of the document.**

As a practitioner at SW Therapy & Rehab, LLC, I understand that it is not in my scope of practice to diagnose, treat disease or to give any advice about prescription medications. In addition, I agree to inform my clients in writing of the following:

___I understand that the practitioner I am seeing is not a licensed physician by the State of New Mexico and that no medical diagnosis, treatment or cure will be rendered for medical conditions.

___The treatment they will receive from me is alternative or complementary to healing arts services licensed by the state of New Mexico.

___The nature and expected results of the complementary and alternative health care services to be provided.

___ I understand that it is my responsibility to inform the kinesiologist of any pre-existing conditions or sensitivities that will contraindicate or limit the session. I understand that it is important for me to inform my kinesiologist if I feel pain or discomfort during my session. It is my responsibility to adjust the quality of touch in response to my communication.

___The client has full and accurate disclosure of my education, training, experience, and other qualifications regarding the services to be provided.

___The Client has a right to complete and current information concerning the complementary and alternative health care practitioner's assessment and recommended complementary and alternative health care services that are to be provided, including the expected duration of the complementary and alternative health care services to be provided and the Client's right to be allowed access to the Client's records and written information from the Client's records.

___Client records and transactions with the complementary and alternative health care practitioner are confidential unless the release of these records is authorized in writing by the Client or otherwise provided by law;

___Client has a right to coordinated transfer when there will be a change in the provider of complementary and alternative health care services; and

___Client may file complaints with Star Ridsdale by e-mail or phone: star@southwesttherapy.com or 505-239-9644.

___I understand that I am responsible for payment at the time of service. We accept cash and credit cards.

___I understand that if I miss a scheduled appointment I will be billed for the full cost of the appointment I have missed. We require a 24-hour notice of cancellation of your appointment.

___I understand if I am more than 15 minutes late for my appointment we may have to reschedule. We try very hard to stay on time with our appointments, your promptness helps us to do that and gives you the full treatment time that you deserve.

___Any supplements that are needed will be ordered and shipped to your address. Supplements are not included in the price of your visit.

Furthermore, I agree to provide each client with a copy of the written acknowledgement, and I agree to keep the original on file for at least three years.

I have read, understand and agree to this financial policy and disclosure statement.

PRINT NAME:

_____

PRINT ADDRESS:

_____

SIGN: _____

DATE: _____