SENIORITY WELLNESS
&Consulting LLC
living well your way

Office: 513-799-8263
Fax: 513-912-0993
Email: info@seniioritywc.com

Client Service Agreement and Consent for Treatment

This Client Service Agreement ("Agreement") is between Seniority Wellness & Consulting, LLC, an Ohio limited liability company , ("we" or "us") and our clients ("you" or "the client")

1. **Term.** The term of this Agreement will run from the date it is signed by both parties on an as needed basis until terminated by either party, or provided here under
2. **Services**: We will provide skilled physical therapy services as per the below terms and a service plan which shall be developed in consultation with you and your designated representative or family member. Services may be provided in your home, or in a mutually agreed upon alternate designated location (i.e fitness facility, family member's home, work space). We may reject any alternate location proposed in our sole discretion.
3. **Fees and Billing**: Fees are set forth as follows and are per session
    a. $175 Evaluation with Treatment/ Consultation
    b. $125 Follow up visits

Session lengths may vary between 75-90minutes for initial Evaluation; 45-60 minutes for follow up visits. Session times are determined based on our discretion and our professional judgement. All individual sessions are billed on the day of service to the client or third party payor (if a Medicare beneficiary). If the client has a financial obligation to cover services in combination with their insurance benefit they will receive a statement of all total charges at the end of the month. Statement balances must be satisfied within 2 weeks of being issued a statement. Failure to pay your statement balance within two weeks of it being issued will result in discontinuation of services. All other clients who our services are "out of network" with their insurance and private pay clients; their services are due on the day services are rendered. Forms of acceptable payment include a Credit Card, Cash or Check (made out to Seniority Wellness & Consulting). We will assess a $25 fee for all returned checks.

Initial_____

4. **Payment disclaimer**: I authorize Seniority Wellness & Consulting LLC and its representatives to share records and information with third parties participating in my therapy including any party through which an insurance program is paying for all or part of my therapy (if applicable). I authorize Seniority Wellness & Consulting LLC to act on my behalf with any reasonable and necessary appeals in regard to services provided by Seniority Wellness & Consulting LLC. I authorize payment be made directly to Seniority Wellness & Consulting LLC. I understand that I am responsible for any copays, deductibles and services not covered by a third party payer

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5. We are a mobile outpatient therapy provider and will provide the majority of services in your home. If at any time your physician orders a home health agency to service you for therapy or nursing in your home and they initiate care please notify us immediately. Medicare guidelines indicate that a beneficiary cannot be covered for Medicare A (covering the home health agency's services) and Medicare B (outpatient services) services at the same time. Failure to notify us of this change will result in the client being assessed for all charges due to this change in their healthcare status. This change will also result in an immediate discontinuation of our services **Initial_____**

6. Seniority Wellness & Consulting LLC prides ourselves on being on time and always available for patient appointments, however there may be instances where your therapist is sick or unable to keep your appointment. If there is a scheduling conflict for the therapist, you will be contacted as soon as possible via text, call, and/or email (per patient preference) to reschedule your appointment. If your appointment must be canceled or rescheduled due to a staff member conflict, you will not be charged a fee and we will reschedule your appointment to the soonest possible date and time
7. **Confidentiality**: Professional and personal ethics require us to keep your medical information confidential. We will not discuss such information with anyone without your permission, except as allowed by those rules or as required bylaw, provided that you expressly agree that we may release any such information to (a) individuals acting in official capacities as your representative or agent, (b) anyone you designate as being entitled to such information or (c) other health care providers involved in your care.
8. **Governing Law.** The laws of the state of Ohio shall govern this agreement

Consent for treatment. By signing below, I authorize Seniority Wellness & Consulting, LLC to provide treatment to myself for what is considered medically necessary for my physical condition. I understand that I am agreeing to those services that Angela Onyekanne, DPT is qualified to provide within the scope of the provider's license, certification and training, and under the terms set forth in the Client Service Agreement.

Name (please print)_____

Signature (client; client representative)_____

Witness Signature:_____

Date:_____