

HEARTLIGHT HEALING ARTS
8975 Guilford Road, Suite 170
Columbia, MD 21046

POLICIES AND PROCEDURES

Payment:

Payment for appointments is expected at the time of service. We accept Visa, Master Card or Discover credit cards.

Insurance:

Dr. Compart does not participate with an insurance plans. We do not file forms directly with insurance companies. We will provide you with invoices which include all standard information you will need to submit your claim directly to your insurance company (such as CPT codes, ICD-10 diagnosis codes, etc.)

Cancellation policy:

When a patient cancels shortly before an appointment or is a “no show,” we miss the opportunity to provide care to other patients during that time slot. Therefore, appointments must be cancelled 24 hours in advance. Cancellation needs to be done within one *business* day. For example, if your appointment is on a Monday, the appointment would need to be cancelled by the preceding Friday. Patients who do not cancel their appointments within this time period or who miss a scheduled appointment will be billed a \$50 missed appointment fee.

Appointments:

Dr. Compart’s initial evaluation consists of three appointments. If substantive lab tests are ordered, a billable follow-up appointment will be necessary to review those results in detail. Subsequent routine follow-up appointments are done every four months, though the frequency may vary depending on a patient’s individual needs. Please see the Administrative page on our website for more details on how the appointments are done and our current fees.

Email:

Dr. Compart does communicate by email. Email is not to be used for urgent or emergent issues. Emails are checked on days Dr. Compart is regularly scheduled to be in the office.

Need for primary care physician:

Dr. Compart does not function as your child’s primary care physician. Your child must have a primary care physician in order to be treated by Dr. Compart. Dr. Compart functions as a specialty physician. She communicates with physicians as needed to coordinate and facilitate

your child's care.

I have read and understand HeartLight Healing Arts' policies and procedures and am in agreement with the above.

Patient's name (printed)

Signature of patient (or parent/legal guardian)

Parent/Legal guardian's name (printed)

Date