277 Peninsula Farm Rd.
Building 3, Suite "I"
Arnold, MD 21012
202-681-1779
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Welcome to Magothy Therapy & Wellness!

While we provide a wide variety of services, we are not a preferred provider with any medical insurance. Since we are not in network with any insurance, we are not restricted by their guidelines and do not need to limit the amount of time spent with our patients or the quality of care. Instead, we provide occupational therapy using a "fee for service" model.

We provide an insurance worksheet to assist you with asking the appropriate questions to your insurance company. Prior to your first visit, please call your insurance company to fully understand your reimbursement benefits. At your first visit we will provide you with a statement that you can submit to your insurance company, so they may consider reimbursement. The amount of reimbursement you receive may vary. Reimbursement rates can range from 0-80%.

As per Medicare rules we do not provide occupational therapy services to Medicare patients. Please see our Medicare Clarification letter.

Appointment Information

_____ (Initials) Please arrive on time for 5 minutes prior to your appointments.
_____ (Initials) There will be no extensions in care due to lateness as the therapist is on a set schedule.
_____ (Initials) Magothy Therapy & Wellness requires 24 hrs notice of your cancellation. You will be responsible for a cancellation fee of $50 if notice is given less than 24 hrs.

_____ (Initials) If the visit is missed completely (no show) or cancel within 1 hour of the appointment you will be responsible for the cost of the visit.
_____ (Initials) Payment can be made in the form of a cash, check or credit card.
_____ (Initials) I understand and I agree that I am responsible for full payment of my bill at the time of service.

I understand the cost of therapy is as follows:
_____ (Initials) Initial Evaluation: $ 180
_____ (Initials) Follow up sessions: $ 150

If you have any questions or concerns, please speak with your therapist.

Patient/Guardian Signature _____

Printed Patient/Guardian Name _____

Date _____