Dear Patient:

We are pleased that you have chosen our clinic for your physical therapy treatment. We strive to provide you with the highest quality of care possible so that you can reach your full potential. For this reason, you will only be seen by a physical therapist licensed in the state of Washington.

It is extremely important that you are aware of your insurance coverage for physical therapy. Please review the following information. Our office staff will try to answer any questions you might have.

INSURANCE INFORMATION:

1. Private Insurance: Coverage of physical therapy is included in most insurance policies; however, you are expected to check your specific policy for appropriate coverage since you are responsible for payment of your account. We will gladly bill your primary insurance company

2. Labor and Industries: It is extremely important that you follow through with your physical therapy program. Failure to comply with your program may mean suspension of your benefits.

3. Medicare: Our office accepts Medicare Assignment, which means our clinic will accept the Medicare approved charge as the full charge for covered services. Medicare will then pay 80% of the approved charge. The beneficiary or their Medicare Supplement is responsible only for the 20% that the Medicare does not pay plus any unmet deductible. Our clinic bills Medicare directly. **Please let us know if you are receiving Home Health Care services. Medicare will not cover out-patient physical therapy if you are receiving Home Health Care.**

4. DSHS: Before treatment can begin we must have a current referral from your doctor and a copy of your insurance card before you receive treatment.

Cancellation Policy: If you do not call and cancel your appointment at least 4 hours before your scheduled appointment, you may be charged a $25.00 cancellation fee.

No show policy: If you fail to show for three scheduled treatment sessions, not only will you be subject to the $25.00 cancellation fee, but you will be discharged from physical therapy.

Patient Name
(Printed) _____

Patient/Guardian Signature_____ Date _____