

**Woodinville Physical Therapy**  
**Woodinville Hand Therapy**  
**Orthopedic Physical Therapy**  
**Sports Rehabilitation**  
**Disorders of the Spine**

**WELCOME**

Your physician has referred you here to aid in your medical program and in his or her assessment of your needs. On your first visit you will be thoroughly evaluated. On the basis of that evaluation and your physician's recommendations, an appropriate treatment will be proposed. The therapist will explain your program thoroughly and will work with you to establish some functional goals that should be realized with therapy.

A copy of the evaluation and the proposed treatment plan will be sent to your physician. As your particular condition changes, so may the treatment you receive. Close communication between your therapist and your physician regarding these changes will be maintained.

Your rehabilitation is important to us. In order to maximize your time here, and in consideration of other patients, we request that children not be brought to therapy sessions. However, if it is absolutely necessary that your child come to therapy with you, we ask that you keep your child close to you at all times. Also, for their safety, children are not allowed to use any of the equipment.

**PATIENT FINANCIAL AGREEMENT FOR BILLING HEALTH INSURANCE**

You, the patient, are responsible for the bill for all services rendered you by the PROVIDER. PROVIDER may bill certain insurance companies strictly as a courtesy to you. At the discretion of the PROVIDER, we will bill some health insurance agencies, auto insurance agencies, attorney/law firms, worker's compensation claims and Medicare, provided you are eligible for the requested medical services. We accept assignment only from the Department of Labor and Industries, Medicare, and certain HMO/PPO's as payment in full, subject to payment of your co-pays and deductibles, provided your respective insurance company/prepaid health plan administrator audits and pays your claims properly and correctly. If this does not occur, or your claim is rejected for any reason, including your failure or inability to bill your insurance provider, you will be responsible for the differences of any amounts due. Any deductibles not met, differences in coverage, applicable co-insurance payment, as well as services not covered under your insurance contract, must be paid, in full, at the time of each office visit. We ask that you check with your insurance to verify your coverage for therapy. By billing these insurance companies or waiting for settlement of your accident case, we are extending credit and reserve the right to inquire about credit and contact all three credit recording agencies to determine whether credit should be extended. Patients may ask to inspect our fee list. Patients who have no insurance coverage or whose insurance we do not bill directly will be required to pay for all medical services at the time of each visit.

Initials \_\_\_\_\_

If your health insurance company has not paid within 45 days after the date services were rendered, our office will notify the patient of the amount due. It will then become the sole responsibility of the patient to deal with their insurance company when there is a question or nonpayment for services rendered.

Initials \_\_\_\_\_

All patients paying for balances via personal check will be responsible for an addition fee of \$35.00, per RCW 62A.3-515 & 520 on checks returned from the bank containing "Non Sufficient Funds" or issues a stop payment order on a credit card.

Initials \_\_\_\_\_

Our fee for not appearing for a scheduled appointment is \$38.00. We will waive our fee provided that we have twenty-four (24) hours advance notice of any cancellations. If you do not appear or “no show” for two scheduled appointments, all subsequent scheduled appointments will be cancelled and will need to be rescheduled. If you arrive 15 minutes late for your scheduled appointment it may be considered a “no show” appointment.

Initials \_\_\_\_\_

I hereby authorize my insurance benefits to be paid directly to the clinic. I authorize the release of any medical or other information necessary to process insurance claims. Office fees, no-show fees, billing policies, NSF fees, are all subject to change at the discretion of PROVIDER. By signing this agreement, it is understood that you, or as the guardian of a minor, understands and agrees to abide by our patient financial policy and will accept the conditions thereof.

\_\_\_\_\_  
PATIENT

\_\_\_\_\_  
DATE

\_\_\_\_\_  
LEGAL GUARDIAN

\_\_\_\_\_  
DATE