

**EDMONDS PHYSICAL THERAPY & SPORTS REHABILITATION, P.S.**  
7315 212<sup>TH</sup> Street SW, Suite 104-Edmonds, WA 98026 (425) 774-3226

**CLINIC POLICIES**

I, the undersigned, hereby authorize Edmonds Physical Therapy and Sports Rehabilitation, P.S. to receive the benefits to which I, or my dependents are entitled to under my health insurance plan. **I understand that all fees are my responsibility**, and I will pay Edmonds Physical Therapy and Sports Rehabilitation, P.S. the full amount due after my insurance company has processed claims. Should the account exceed an amount that I am able to pay in full; a payment plan between the undersigned and the clinic can be established. All accounts 90 days past due and without an agreed upon payment plan in current standing will be referred for collections. The undersigned shall pay all reasonable collection expenses including interest on the unpaid balance at 1.0% per month from the date of service, and/or reasonable attorney fees and court costs.

**COPAYMENTS:** All patients that have a co-payment agreement with their insurance company are required to pay their co-payment amount at the time of each appointment.

**APPOINTMENT CANCELLATION:** We require 24-hour notice for appointment cancellations. When canceling an appointment, the patient is expected to have an alternate time/day in mind to reschedule the appointment. This allows that the proper number of treatment sessions be attended, per your physician's order. When rescheduling, it may be necessary to schedule with another staff therapist. Repeated appointment cancellations will result in a \$35 fee assessed to your account. This fee is due prior to your next scheduled appointment.

**LATE ARRIVALS:** In consideration of other scheduled patients, should you arrive more than 10 minutes late for your scheduled appointment time, you may be required to reschedule your appointment.

**\$35.00 FEE FOR MISSED APPOINTMENTS:** Your insurance company will not cover this fee. You will be responsible for payment of this fee before your next scheduled appointment. Please understand that during your course of treatment, you will experience changes in the amount of your discomfort. Initially there could be some additional soreness before your condition begins to resolve, or you may notice a sudden reduction in your pain. In either situation, it is important that you **keep your scheduled appointments** so that we may further treat your condition until it is resolved, and you have been adequately educated in future prevention/care.

**INSUFFICIENT BILLING INFORMATION:** You are expected to notify us of changes to your personal contact, or insurance, information. We will bill your insurance for you, provided you supply us with accurate billing information. Ultimately, you are responsible for all charges incurred with us. If you should arrive for your first scheduled appointment with a lack of necessary billing information, you may be required to reschedule the appointment for a time when you are able to provide the required billing information.

**SECONDARY INSURANCE BILLING:** If we have a current contract with your secondary insurance, we will bill them for you, **one time only**, as a courtesy and a convenience to you. Any balance left unpaid by your secondary insurance is patient responsibility.

**\$20.00 FEE FOR 'INSUFFICIENT CHECKING FUNDS':** This fee will be assessed to your account for each check returned for insufficient funds. You will be responsible for payment of this fee, as well as the amount of the original 'insufficient funds' check before your next scheduled appointment.

I, the undersigned, authorize the release of all pertinent information contained within my medical records which may be necessary to process this claim for insurance benefits.

Signature by patient/guarantor authorizes Edmonds Physical Therapy and Sports Rehabilitation, P.S. to render service and guarantees payment by the responsible party.

**Patient/Guarantor Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_