# OrthoSport Physical Therapy, LLC

**19217 36th Ave. West, Suite 102**
**Lynnwood, WA 98036**

## Patient Responsibility

Welcome to OrthoSport Physical Therapy. Thank you for choosing this facility for your rehabilitation. We look forward to serving you with the highest quality of care available. Please take the time to read the following information.

**Arrival:** Please arrive on time for all appointments. If you are going to be late, please call.

**Scheduling:** Please schedule your next appointment(s) before you leave.

**Payment:** If treatments, certain procedures that are part of your treatment, or supplies are not covered by your insurance, or your coverage requires co-payment for services, payment is expected at each treatment session. In addition, if your insurance company does not provide payment within 90 days from the date of service, and a reasonable attempt has been made by our staff to collect payment from them, then you will be billed for the services. Other payment arrangements may be considered upon prior approval.

**Cancellation Policy:** Your attendance is important to your recovery. If you are unable to attend a treatment session, please notify us at least twenty-four hours (24 hours) prior to your appointment time. If you do not show for an appointment and/or do not call to give 24-hours notice before your appointment to cancel, it will be considered a no show. You will be charged a $40.00 no show fee. We reserve the right to discontinue your therapy if you have two (2) no shows or three (3) cancellations in two (2) weeks. Please note that workers' compensation laws require us to inform the employer and carrier of any non-compliance issues.

**Patient Participation:** It is our responsibility to give you excellent care and to educate you concerning proper exercise and health principles. It is our hope to inspire you to take responsibility for your own health and well being by complying with the programs given by your therapist to perform in the clinic and at home.

**Authorization for Treatment, Assignment of Insurance Benefits, Guarantee of Payment, Release of Records:**
I hereby guarantee payment of all charges incurred for my course of treatment. I understand that no guarantee has been made concerning the results of treatment. I understand that I must pay any copay, coinsurance, or deductible due at the time of service unless other arrangements have been made with OrthoSport Physical Therapy. I understand that certain procedures or supplies may not be covered by my insurance company. While I understand OrthoSport Physical Therapy will verify my benefits, I agree that it is ultimately my responsibility to know what is covered or not covered under my insurance plan. I further agree to pay, upon receipt, any bill from OrthoSport Physical Therapy for services or products not covered by my insurance company.