

PATIENT NAME: \_\_\_\_\_

**Willow Physical Therapy**  
1919 Lathrop St. Suite 222  
Fairbanks, AK 99701  
907-456-5990 OFFICE PHONE  
907-456-7418 FAX NUMBER

**HOURS OF OPERATION**  
**MONDAY THROUGH FRIDAY 8:00 AM to 5:30 PM**

## **PATIENT AGREEMENT**

Willow Physical Therapy offers physical therapy services for patients referred to our practice. We are a licensed provider who develops individualized treatment plans to identify the services that will best suit your therapy needs. We work with your primary care practitioner to coordinate your care.

Following your initial assessment visit(s), we develop a specific plan of care. We are pleased to serve your physical therapy needs and encourage your feedback to alert us to anything we can do to provide you the highest quality of care.

Intake forms which provide us with necessary information must be completed before beginning treatment. Please do your best to complete all the information. If certain information does not apply to you, please indicate that by noting "N/A" ("Not Applicable") so that we know that you did not overlook anything.

Each healthcare insurance payer has different guidelines for allowing coverage of physical therapy services which you as the insured are responsible to know. Lack of, or inaccurate reporting of insurance coverage may result in you having to pay for your treatment. If you are a Medicaid beneficiary, please ask your primary care provider to send us a referral for your initial assessment to fulfill Medicaid requirements.

### **ALASKA MEDICAID RECIPIENTS:**

Alaska Medicaid requires that a physician, physician assistant or advanced nurse practitioner refer you to our practice before we can perform an initial assessment on you. After we have completed your initial assessment, we develop an individualized Treatment Plan to meet your specific therapy goals.

Your primary care practitioner will need to review & approve your Treatment Plan, and then return it to our practice before we can begin your treatment. Please understand that we cannot schedule your therapy appointments until after we have received your approved Treatment Plan.

### **NO SHOW POLICY**

We will schedule your follow up appointments after your first visit. To facilitate the effectiveness of your treatment *it is important to be consistent with your appointments*. If you cannot make it to a scheduled appointment, please contact our office at least 24 hours in advance. After hours you may leave a message on our voicemail. If you miss two consecutive appointments without notice, any remaining appointments will be cancelled and you will need to call to reschedule further appointments.

## **WAIT LIST FOR SERVICES**

If you would like to reschedule an appointment for a day or time that is not available, please let us know and we will place you on our waiting list. If another patient cancels their appointment, we will contact patients on the waiting list on a first come, first call basis.

## **MEDICARE, MEDICAID & PRIVATE INSURANCE CO-PAYMENTS, DEDUCTIBLES AND NON-COVERED SERVICE**

Medicare has a limit on the amount of physical therapy services they pay for. Once you have exceeded the financial limit of your Part B benefits, and you do not have additional healthcare coverage, you are responsible for the payment of your services. Additionally, Medicare and private healthcare insurance payers have deductible and co-payments for physical therapy services that are the responsibility of the patient. Co-payments must be paid at the time of service for all patients. Uninsured cash patients are expected to pay at the time of service and are offered a 10% discount.

## **FINANCIAL AGREEMENT**

All patients approved for physical therapy services are responsible for any and all charges not paid for by the insurance carrier (with the exception of Medicare, Medicaid, etc.). As a courtesy to you, Willow Physical Therapy will bill your insurance carrier for rendered services. By signing this patient agreement, you are acknowledging that you understand this condition of service and commit to promptly paying Willow Physical Therapy for the services we provide to you, our valued customer. Following the receipt of your monthly patient statement, please remit payment within 30 days. We accept cash, personal checks, money orders, and credit cards VISA, Mastercard, American Express. There will be a \$25 fee for all returned checks. For any questions please contact our Billing Office at 907-456-5990.

## **QUALITY ASSURANCE & COMPLAINT RESOLUTION**

Should you or your caregiver experience a situation that requires the attention and resolution of a Supervisor and/or Manager, please contact our practice either by phone or in writing; you may also contact our clinic manager at 907-456-5990. Our Manager will interact with you to reach a resolution of any identified situation where our quality of service has been compromised. We use such situations to alert us to improvements we can make to better serve all our patients.

I received a Willow Physical Therapy HIPAA Privacy Statement. Initials \_\_\_\_\_

## **PATIENT STATEMENT OF AGREEMENT**

My signature below signifies that I have read and understand this patient agreement for Willow Physical Therapy to provide me physical therapy services. I agree to the terms in this patient agreement and agree to comply. I understand that if I fail to follow the terms of this agreement, I could be discharged from service.

I authorize the release of any medical information necessary to process my insurance claims. I authorize any payments of medical benefits to be paid directly to Willow Physical Therapy.

**Signature** of Patient or Personal Representative:  
(Or Witness if signature is by mark)

Date:

**Printed Name of Personal Representative** or Witness Description of Personal Representative's Authority: