



WELCOME!

Thank you for contacting our office! Alternative Back Care Physical Therapy is not your traditional physical therapy clinic. We have innovative and revolutionary techniques specializing in back pain and migraines, as well as treatment for on the job injuries, sports injuries, fall prevention and auto accidents.

_____ has an appointment with our clinic on _____ (date) at _____ (time). We look forward to meeting you! Please contact us with any questions that you may have. If you need to cancel your initial appointment we do require a 48 hour notice. The cancel fee is for initial evaluations is \$75 and your insurance will not be responsible for this charge.

FOR YOUR INITIAL EVALUATION:

If your insurance requires a referral we will need the referral prior to your first appointment. Please bring the referral and your insurance card or medical coupon to your first visit so we can copy it for your therapist. If you are unsure if a referral is required, please ask the front desk staff or contact your insurance company.

Please complete all attached forms required for our clinic before your appointment time and bring all paperwork with you for your visit. This will ensure a quick check in process!

Most insurances and managed care contracts require us to collect co-payments/co-insurances at the time of the visit. For your convenience we accept personal checks, cash, Visa or MasterCard.

New Patient Information and Expectations:

- We wish to provide you with excellent and professional service here at Alternative Back Care Physical Therapy. Please let us know if you have any questions, concerns or suggestions.
- You should expect the same results and relief from treatment with every therapist. Typically most all patients leave feeling better. Please ask your therapist to explain on your first visit.
- If you experience discomfort during manual therapy, it is vital that you let your therapist know right away so a different approach can be used. Open communication with the therapist about how treatment is going is the key to relief. We always welcome your feedback.
- We suggest wearing loose fitting and comfortable clothing during your appointment.
- Please turn cell phones off or on vibrate during your appointment time.
- We do expect that you arrive on time for all appointments and give at least a 24 hour notification if you will not be able to make an appointment. In instances with less than a 24 hour notice given (except in serious emergencies), or a no-show to an appointment we reserve the right to charge a \$25.00 fee.
- If you bring your children to our clinic we ask that they stay in the play area and that they are quiet and well behaved. Children are also not allowed in the gym or to run inside for safety reasons.

I read and understand patient information and expectations. **Initial:** _____ **Date:** _____

Alternative Back Care Physical Therapy
3502 South 12th Street Suite B, Tacoma, WA 98405
Phone: 253.564.2220 Fax: 253.564.2221

ALTERNATIVE BACK CARE PHYSICAL THERAPY'S POLICIES

Thank you for choosing us to provide your Physical Therapy care. The following statements are our policies which we require you read, agree to and sign prior to any treatment. Any questions, please ask our front desk staff.

Financial Policy

If you have insurance: Our office will contact your insurance company to determine eligibility and benefits available for physical therapy. Your insurance company may cover a portion of your bill, but you are responsible for the balance of your bill. It is the patient's responsibility to pay for the costs related to their therapy, including deductibles, co-pays and co-insurances at time of service.

If no insurance is available, we collect payment at time of service. Please ask for our cash pay rate. *We accept personal checks, cash, Visa or MasterCard for your convenience.*

If L&I: Please have your date of injury and claim number available. We will work with you and Labor and Industries for payment, but if your claim is denied we will attempt to bill your personal insurance carrier for reimbursement, but if they deny the charge, you will be responsible for payment.

I Hereby agree to full responsibility for all the expenses incurred by or on this account. I authorize my insurance company to pay Alternative Back Care Physical Therapy directly for services rendered. I agree that I will pay any remaining balance no later than 30 days following the insurance payment. I understand an administrative service charge of 1% compounded or a \$1.50 per month, whichever is greater, will be charged on all unpaid balances.

Signature: _____

Date: _____

Missed Appointment Policy

Your adherence to the recommended number of treatments is a vital component of your progress with our services; therefore attendance is extremely important to ensure most optimum results. We work with you and your doctor to provide a strong plan of care and attendance is necessary to achieve relief.

We expect you to keep all your appointments. If you need to reschedule an appointment, we require at least a 24 hour notice (with the exception of serious emergencies). Please call our office to arrange your rescheduled appointment. In an instance of a cancellation or no-show to a scheduled appointment, we reserve the right to charge you a \$25 fee.

In instances of repeated non-compliance with your scheduled visits, we reserve the right to discontinue care and inform your physician of discontinued service due to non-compliance with prescribed rehabilitation order. Our goal is to follow the prescribed plan of care and achieve results. Attendance is crucial. We appreciate your efforts as we work together to accomplish results and success.

Signature: _____

Date: _____

Privacy Policy

I acknowledge Alternative Back Care Physical Therapy's Privacy Practice. If you require a copy of our privacy practice notice please ask our office staff.

Signature: _____

Date: _____

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