Client Care Agreement - All AHCCCS Patients

As an AHCCCS patient, in order to optimize the provider–patient relationship between myself and Backway's Physical Therapy, PLLC, I request and agree to the following terms:

Backway's Physical Therapy agrees to:

1. Provide me/my dependent one-on-one personalized care, by scheduling individual treatment time.
2. Waive the $2.30 co-pay.

I, ____________________________________, agree to:
Client name

1. Show up on time and ready for appointments.
2. Call the office 24 hours before scheduled appointment time, if for any reason I am unable to make the appointment.
3. Pay a no-show / late cancellation fee of $25.00 in the event that I do not notify the office 24 hours before a scheduled appointment time.

Signed ____ Date _________________

Additional stipulations for treatment:

Arizona State Law limits the number of Physical Therapy visits paid by AHCCCS to 15 visits per year (Oct. 1 thru Sept. 30) for all members over the age of 21.

By signing below, I am verifying that I understand it is my responsibility to keep track of my 15 visits per year, and, if for any reason I exceed my 15 visits, I understand that AHCCCS will deny payment, and I will be billed for these visit(s). I agree to pay for all visits that exceed my covered benefits.

Signed ____ Date________________

Printed client or guardian name ____