CONNECT PHYSICAL THERAPY

17120 Pilkington Road, Lake Oswego Oregon 97035 503-974-9078

NAME_____ TODAY'S DATE_____

ADDRESS_____ HOME PH #_____

CITY_____ ST_____ ZIP_____ CELL PH#_____

SEX____M____F GENDER IDENTITY_____ PREFERRED PRONOUN_____ BIRTHDATE_____/_____/_____

E-MAIL_____ WORK PH#_____

REFERRING DOCTOR_____ PRIMARY DOCTOR_____

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IS THE PATIENT A MINOR?____YES AGE_____ RESPONSIBLE PARTY'S NAME_____ DOB_____

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PRIMARY INSURANCE CO._____PHONE#_____

MEMBER ID#_____ GROUP#_____

SUBSCRIBERS NAME_____ SUBSCRIBERS DOB_____

SECONDARY INSURANCE CO._____
PHONE#_____

MEMBER ID#_____ GROUP#_____

SUBSCRIBERS NAME_____ SUBSCRIBERS DOB_____

MOTOR VEHICLE INSURANCE CO._____CLAIM #_____

MEDICAL ADJUSTOR NAME_____ PHONE#_____

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PAYMENT & CANCELLATION AGREEMENT, CONSENT TO TREAT, AUTHORIZATION TO RELEASE INFORMATION

I UNDERSTAND & AGREE TO THE FOLLOWING:

CONNECT PHYSICAL THERAPY REQUIRES ONE FULL BUSINESS DAY/24 HOURS ADVANCE NOTICE TO CANCEL AN APPOINTMENT. A CANCELLATION FEE OF $50.00 WILL BE CHARGED FOR VISITS CANCELLED LESS THAN ONE FULL BUSINESS/24 HOURS IN ADVANCED. PLEASE INITIAL HERE_____

KNOWLEDGE OF MY INSURANCE BENEFITS AND PAYMENT FOR ALL PHYSICAL THERAPY SERVICES IS MY RESPONSIBILITY REGARDLESS OF INSURANCE OR THIRD PARTY COVERAGE. AS A COURTESY CONNECT PHYSICAL THERAPY WILL PROCESS YOUR INSURANCE CLAIMS AND WILL SEND YOU A MONTHLY STATEMENT. PAYMENT MAY BE MADE USING CASH, CHECK, OR CREDIT CARD. INSURANCE CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE. I AUTHORIZE PAYMENT OF MY MEDICAL BENEFITS TO CONNECT PHYSICAL THERAPY. CREDIT BALANCE ON YOUR ACCOUNT WILL BE REFUNDED PROMPTLY.

I AUTHORIZE CONNECT PHYSICAL THERAPY TO KEEP MY CREDIT CARD ON FILE WITH EASY PAY CREDIT CARD COMPANY AND TO CHARGE MY ACCOUNT FOR OUTSTANDING BALANCES BASED ON A SIGNED CONSENT AGREEMENT. PLEASE INITIAL HERE_____

FOR CLAIMS IN LITIGATION OR DISPUTE PRIOR ARRANGEMENTS MUST BE MADE FOR CONSENT PAYMENT ON YOUR ACCOUNT.

I VOLUNTARILY CONSENT TO TREATMENT BY CONNECT PHYSICAL THERAPY, INCLUDING THE USE OF TELEHEALTH VISITS, AND HAVE THE RIGHT TO REFUSE ANY PROCEDURE FOLLOWING ITS EXPLANATION.

I AUTHORIZE RELEASE OF ALL INFORMATION ACQUIRED DURING THE COURSE OF TREATMENT, INCLUDING MEDICAL RECORDS, ELECTRONIC MEDIA, AND ORAL COMMUNICATIONS TO MY INSURANCE COMPANY, THIRD PARTY PAYERS, PHYSICIANS AND OTHER PROVIDERS INVOLVED IN M CARE. I AUTHORIZE PHONE MESSAGES REGARDING MY TREATMENT AND APPOINTMENTS TO BE LEFT WITH PERSONS OR MACHINES AT THE NUMBERS I PROVIDE. CONNECT PHYSICAL THERAPY IS COMMITTED TO MAINTAINING YOUR PRIVACY. A COPY OF THE STATEMENT OF PRIVACY NOTICE HAS BEEN MADE AVAILABLE TO ME.

SIGNATURE_____ DATE_____