

CONNECT PHYSICAL THERAPY

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

NAME _____ TODAY'S DATE _____

ADDRESS _____ CELL PH # _____

CITY _____ ST _____ ZIP _____ OTHER PH# _____

SEX ___M___F GENDER IDENTITY _____ PREFERRED PRONOUN _____ BIRTHDATE ____/____/____

E-MAIL _____ DOCTOR _____

HOW DID YOU HEAR ABOUT US? _____

IS THE PATIENT A MINOR? ___YES AGE _____ RESPONSIBLE PARTY'S NAME _____ DOB _____

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# _____

PAYMENT AGREEMENT, CONSENT TO TREAT & AUTHORIZATION TO RELEASE INFORMATION

I UNDERSTAND & AGREE TO THE FOLLOWING:

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 _____