Columbia Gorge Physical Therapy & Sports Medicine Inc.

Patient Information

Name: _____ SS#: _____-_____-_____ Gender: M ◯ F ◯ X ◯

Address: _____ City: _____ State:_____ ZIP:_____

Home Phone: (_____) _____ Message Phone: (_____) _____

Birth Date: _____/_____/_____ Email address: _____

Relative/Emergency Contact: _____ Phone: (_____) _____

How did you hear about us: Physician _____ Internet _____ Facebook _____ Friend _____ other (_____)

Financial Policy Agreement

As a service, Columbia Gorge Physical Therapy, Inc. will submit the charges for your treatment to your primary and secondary insurance. However, it is your responsibility to pay any amount not paid by your insurance.

I authorize payment of medical benefits to Columbia Gorge Physical Therapy, Inc. for professional services rendered

NOTIFICATION OF PATIENT RESPONSIBILITY: Columbia Gorge Physical Therapy & Sports Medicine verifies your benefits with your insurance carrier but does not guarantee any information given to us regarding benefits, authorization, or network plan. We advise that you check with your health plan for a complete understanding of your medical coverage/PT benefits. If the information provided by your insurance company or by you is not accurate or the insurance company changes its coverage, you will be responsible for payment of services. Our office is committed to helping you maximize your benefits. If you have any questions, we will be more than happy to help answer them. **All applicable fees, co-pays or supply purchases must be paid at the time of your appointment. We accept cash, checks, VISA, MasterCard, CareCredit.**

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CONSENT FOR TREATMENT AND RELEASE OF INFORMATION

1. I am aware of my diagnosis and wish to receive treatment from CGPTSM. I permit its employees and all other persons caring for me to treat me in ways they judge are beneficial to me. I understand that this care can include an evaluation, testing, and treatment. No guarantees have been made to me about the outcome of the care.

2. I give permission to CGPTSM to release information, verbal and written, contained in my medical record, and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries and all other related persons as it relates to my treatment and/or payment for services provided.

3. I authorize CGPTSM to obtain medical records and/or professional information from my physician or other medical professional as it relates to my treatment.

4. **If patient is a MINOR** , I authorize my child to schedule, change, or cancel their physical therapy appointments

Yes_____ No_____

I have read and understand the above information regarding Columbia Gorge Physical Therapy's policies.

Patient/ (Parent or Guardian) Signature_____Date:_____