

Welcome! Summit Physical Therapy, Inc.

6464 SW Borland Road, Suite B5 Tualatin, OR 97062 503-699-2955

NAME _____ TODAY'S DATE _____
Last (Please print) First MI

EMAIL ADDRESS: _____

HOME ADDRESS _____

CITY _____ ST _____ ZIP _____

HOME PH# _____ CELL PHONE: _____

SEX M F AGE _____ BIRTHDATE ____ / ____ / ____ REFERRING DOCTOR _____

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED PRIMARY CARE DOCTOR _____

IS PATIENT A MINOR? NO YES. IF SO, RESPONSIBLE PARTY _____

RESPONSIBLE PARTY BIRTHDATE: ____ / ____ / ____ RELATIONSHIP TO PATIENT _____

YOUR EMPLOYER NAME _____ OCCUPATION _____

PRIMARY INSURANCE CO _____ PH# _____

POLICY ID# _____ GROUP# _____

SUBSCRIBER'S NAME _____ SUBSCRIBER'S DOB ____ / ____ / ____

SECONDARY INSURANCE CO _____ PH# _____

POLICY ID# _____ GROUP# _____

SUBSCRIBER'S NAME _____ SUBSCRIBER'S DOB ____ / ____ / ____

IS THIS INJURY BEING COVERED BY AN OPEN WORK COMP CLAIM? NO YES

IS THIS INJURY BEING COVERED BY AN OPEN AUTO ACCIDENT CLAIM? NO YES

IF YES TO EITHER, DATE OF INJURY ____ / ____ / ____ INSURANCE CO _____

CLAIM# _____ ADJUSTER NAME _____

ADJUSTER PH# _____ ADJUSTER FAX# _____

INSURANCE COMPANY ADDRESS _____

How did you hear about us?

SUMMIT P.T. WAS RECOMMENDED BY DR. _____ REFERRED BY FRIEND/FAMILY

I AM A FORMER PATIENT SUMMIT P.T. IN NETWORK PROVIDER LIST WEBSITE/ONLINE SEARCH

WORD OF MOUTH SIGN/DROVE BY

ASSIGNMENT & RELEASE OF BENEFITS:

I hereby assign all benefits from the above named insurance(s) to be paid directly to Summit Physical Therapy for services rendered. I authorize the use of my signature on all insurance submissions. Summit Physical Therapy may use my healthcare information and may disclose such information to the above named insurance company (ies) for the purpose of obtaining payment and for determining insurance benefits or the benefits payable for related services.

SIGNATURE

PRINTED NAME

SUMMIT PHYSICAL THERAPY

Policies & Procedures

Please initial beside each section, and sign and date below.

_____ Cancellations:

Three people are affected when you miss an appointment without notice. You don't get treated, another patient misses an opportunity to be seen, and the therapist has a gap in his schedule. Our 24-hour voicemail can take your cancellation call at any time, even when the office is closed. **Please give us a timely notice, preferably 24 hours in advance. Short cancellations and no-shows will incur a \$35.00 charge.**

_____ Co-pays & Deductible:

Insurance co-pays are due at the time of service. If you have an insurance deductible due, you will be asked to pay a minimum of \$50.00 towards that amount at the time of service. Any additional balance will be billed to you after the insurance has completed their processing. We have a returned-check fee of \$25.00.

_____ Financial Responsibility:

We bill your insurance as a courtesy, and will work with the insurance to resolve any denied claims or problems. **However, ultimate responsibility for payment of services rests with the patient.** We are always happy to work with you on payment plans during times of financial hardship, but accounts that become past due without any effort towards payment will be assigned to an outside collection agency, which may adversely affect your credit rating.

_____ Privacy:

Summit Physical Therapy is committed to maintaining your privacy and protecting your personal health information. Your signature below indicates your acknowledgement that you have received a copy of our Patient Privacy Policy.

_____ Release of Information:

Your signature below authorizes us to exchange any information necessary for your treatment with other medical providers involved in your care, including but not limited to history obtained, x-ray and physical findings, diagnosis and prognosis, and record of current treatment plan.

Signature

Date

Printed Name

Relationship to patient (if other than self)

Summit Physical Therapy Patient Privacy Policy

WE ARE REQUIRED BY LAW TO PROTECT THE PRIVACY OF YOUR MEDICAL INFORMATION AND TO PROVIDE YOU WITH A DETAILED WRITTEN NOTICE DESCRIBING HOW THIS CLINIC MAY USE OR DISCLOSE MEDICAL INFORMATION ABOUT YOU AND HOW YOU CAN OBTAIN OR CORRECT THIS INFORMATION.

Here is a brief summary:

- ◆ We may use your medical information or disclose it to others in order to provide or arrange your health care, to arrange payment or reimbursement for the care that we provide to you, or to carry out administrative activities related to or supporting your treatment.
- ◆ We may be required or permitted by certain state or federal laws, regulations, or legal circumstances to use or disclose your medical information for certain purposes without your authorization. Under other circumstances we may need your written authorization (that you may later revoke) in order to use or disclose your medical information.
- ◆ As our patient, you have important rights regarding your medical information in this clinic. You have the right to inspect, copy, amend or correct that information, obtain an accounting of disclosures of your medical information, request that we communicate with you confidentially and request that we restrict certain uses and disclosures of your health information. We have a procedure for filing a complaint if you think your rights have been violated.
- ◆ We will provide a detailed NOTICE OF PRIVACY PRACTICES to you which fully explains your rights and our obligations under the law. We may revise our NOTICE from time to time. The effective date at the top of this page indicates the date of the most current NOTICE in effect.
- ◆ You have the right to receive a copy of our most current NOTICE in effect. If you have not yet received a copy of our current NOTICE, please ask at the front desk and we will provide you with a copy.

If you have any questions, concerns or complaints about the NOTICE or your medical information, please contact Paul Kane of our office at (503) 699-2955.