Oregon Physical Therapy at Timberhill

Consent of Treatment

I hereby consent to evaluation and, or treatment of my condition by a licensed physical therapist employed by or under contract with Oregon Physical Therapy at Timberhill, LLC. I am aware that the physical therapist will inform me of the expected benefits and possible discomfort, which may result from skilled physical therapy care.

I am aware that there is no guarantee that the proposed course of treatment will improve my condition and that it is possible, although unlikely, that the course of treatment may cause additional pain or discomfort or aggravate my condition. I confirm that I have read and fully understand this consent form.

In regards to communication with my therapist, I am aware that e-mail is not a secure method of communication. By initiating or responding to an e-mail, I am giving my consent to communicate in this manner and understand that there are risks to my protected health information.

Release of Information

I Authorize the release of any medical information or other information necessary to process insurance claims by the health practice, Oregon Physical Therapy at Timberhill, LLC.

I understand and agree that Oregon Physical Therapy at Timberhill, LLC may release my medical records and discuss health related, and financially related information or issues to health care providers, insurance representatives, case managers, and lawyers that are involved in my case.

I agree with the HIPAA notice of privacy practices for physical therapy form, freely located at the front desk, and understand I can receive a personal copy upon request at any time.

Assignment of Benefits and Payments

I authorize Oregon Physical Therapy at Timberhill, LLC, to contact and submit billings/ claims to my insurance provider on my behalf, and have these payments be made, and sent to Oregon Physical Therapy at Timberhill, LLC directly. I consent to pay all current and outstanding balances on my account within 30 days of receiving a balance due statement. This includes all co-pays, co-insurances, deductibles, and non-covered charges.

I understand that it my responsibility to personally contact my insurance company to received benefits in accordance of care for physical therapy under my specific plan.

CO-PAYS are due at the time of service. If you must cancel your appointment, do so 24 hours in advance. Should you cancel on the same day or not attend a scheduled appointment there will be a $25.00 charged fee for the missed visit.

PATIENT'S PRINTED NAME: _____

PATIENT SIGNATURE: _____ DATE: _____