PROactive
PHYSICAL THERAPY SPECIALISTS

First Name:_____MI: _____Last:_____

Address: _____City: _____ State:_____Zip:_____
Date of Birth: _____Home Phone:_____ Cell Phone:_____ Work Phone:_____
SSN:_____ Email Address: _____
Employer:_____Employer Phone: _____
Primary Care Physician:_____Date last seen:_____
Emergency Contact Person Name:_____ Phone Number: _____
Financial Responsibility Name, DOB, Address: _____

Primary Insurance:_____Policy Holder Name: _____ Group Policy #:_____
Relationship to Patient:_____Policy Holder ID #:_____Date of Birth:_____
Secondary Insurance: _____Policy Holder Name: _____Group Policy #: _____
Relationship to Patient:_____Policy Holder ID #:_____Date of Birth:_____
Is this work related? Yes/No If yes, date of injury:_____
Is this related to a Motor Vehicle Accident? Yes/No If yes, date of injury _____

**Cancellation and No-show Policy:** We require 24 hours' notice in the event of a cancellation. The charge for cancellation without proper notice is $50. This charge will not be covered by insurance, but will have to be paid by you personally prior to receiving additional treatment. Any future appointments may be automatically cancelled and 2 "no show" appointments may result in discharge from physical therapy.

I hereby give consent for treatment for myself, or the named minor child, by the staff at **Proactive Physical Therapy Specialists** and/or as directed by my referring physician.

I understand that my health information will be used for treatment, payment and healthcare operations, (see the Notice of Privacy Practice). By providing your contact information, you agree to receive information, such as appointment reminders, patient surveys and other information relating to your therapy services via the communication channels you provided above. Please keep in mind that communications via email over the internet is not secure.

I authorized the release of any information necessary to process claims for these services. I authorize release of clinical information for treatment, payment and healthcare operations.

I assign medical benefits payable for these services directly to **Proactive Physical Therapy Specialists.** Balances sent to collections are subject to an additional interest charge of 9% for Oregon or 12% for Washington, depending on which state services are rendered in.

I understand that I am responsible for payment of any applicable co-payments, co-insurance and deductibles at the time of service. In signing this form I understand that I am responsible for the bill not paid my insurance carrier.

By initialing, I confirm that I have been offered a copy of the Notice of Privacy Practices for **Proactive Physical Therapy Specialists.** **Initials:** _____

**I understand and agree to the Financial Policy Statement, Consent for Treatment and Notice of Privacy Practice.**

**Patient/Legal Guardian Signature:**_____**Relationship:**_____**Date:**_____