

# PROactive

PHYSICAL THERAPY SPECIALISTS

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last: \_\_\_\_\_

Mailing 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 \_\_\_\_\_

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**\* \*Cancellation and No-show Policy:** Life happens, and we understand that, but we do require a 24-hour advance notice of cancellation. For your health and well-being, it is VERY important that you attend all your scheduled appointments. **If you frequently cancel or do not show up for your scheduled appointments, your care may be discontinued, and/or a \$20.00 fee may be charged to you. Two "no show" appointments may result in discharge from physical therapy.\*\***  
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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: \_\_\_\_\_

