South Hills Physical Therapy Clinic

4175 East Amazon Drive   Eugene, OR 97405   541-686-0101   541-686-0202 Fax

Patries Kortekaas, P.T., P.C.

Patient Information

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Last Name **First Name** **Middle Initial**

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Birth Date **Sex** **Current Date**

____

Address **Street/Apt. #** **City** **State** **Zip**

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Home Phone **Work Phone** **Cell Phone/Pager #**

Consent to Treat:

Consent/release of information: I, ______________________________, consent to all physical therapy treatments including, but not limited to evaluation, manual therapy techniques, and exercise instruction. My doctor's name is __________________________________, and I authorize Patricia Kortekaas, P.T. to release information to him/her.

Financial Agreement:

I require payment at the time of service. The patient is responsible for the account. My fees are $170 - $265 for the primary visit, which includes an evaluation, diagnosis, and treatment; and $150 per 1 hour standard treatment visit thereafter. **Cash or check only**—no credit cards.

Prescriptions:

THE LICENSING BOARD REQUIRES A DR.'S PRESCRIPTION AFTER A 30 DAYS' LAPSE IN TREATMENTS

Cancellations:

There will be a **$75** fee for all cancellations made less than 24 business hours before a scheduled appointment. Every effort will be made to fill the appointment; if we are able to fill it no fee will be charged.

Agreement:

I understand and agree with the aforementioned consent, prescription requirements, financial agreement, and cancellation fee details.

Patient Signature ____ **Date**______________________

Insurance and Insurance Pre-authorizations:

While we are a "Cash Pay" clinic and full payment is due at the time of services, our office will prepare a receipt for you to submit to your insurance company for reimbursement.

I understand that some insurance companies require prior authorization requirements be met to receive benefits, and that it is my responsibility to verify my insurance benefits for physical therapy. Initial:____________________Date:___________________

Authorization: I authorize the release of any medical or other information necessary to process my claim:

Signature:____**Date:**____________________