South Hills Physical Therapy Clinic

1639 Oak Street, Eugene, OR 97401 Phone: 541-686-0101 * 541-686-0202 Fax

Patricia M. Kortekaas, PT, PC, ANT-c

Patient Information

Last Name	First Name	Middle Initial
Birth Date	Sex	Current Date

Address	Street/Apt. #	City	State	Zip

Home Phone	Work Phone	Cell Phone/Pager #

Consent to Treat:

Consent/release of information for: _____. 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 M. Kortekaas, PT, PC, ANT-c to release information to him/her.

Financial Agreement:

I require payment at the time of service. The patient is responsible for his/her financial account and will need to submit the given proper forms to their insurance company for reimbursement. The patient agrees to organize any pre-authorizations and/or prescriptions necessary according to their plan. I REQUIRE A DR's PRESCRIPTION AFTER 60 DAYS FOR MY LICENSING BOARD. My fees are $180 - $275 for the primary visit, which includes an evaluation, diagnosis, and treatment; and $160 - $240 per standard treatment visit thereafter. Cash or check only – NO credit cards.

Cancellations:

There will be a $100 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.

Continued Reverse >

Agreement:

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

Patient Signature _____ **Date** _____

Insurance and Insurance Pre-authorizations:

While I run a "Cash Pay" practice and full payment is due at the time of services, I 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** _____