washougal sport&spine
PHYSICAL THERAPY

WAIVER & CONSENT

MEDICAL CONSENT

I authorize Washougal Sport and Spine, Inc. to perform an evaluation and any resulting treatments for my current condition and other conditions at my request. I understand that this may include manual testing, measurement of joint and muscle function, manual therapy techniques, therapeutic exercises, palpation, and modalities such as electrical stimulation or ultrasound. I understand that I will be asked to fill out a medical questionnaire and various evaluations will be performed to assure my safety and well being during the evaluation and treatment process. I understand that I am being seen under Direct Access in accordance with all appropriate regulatory agencies. I understand that no Washougal Sport and Spine representative will ask me to do anything that intentionally hurts or injures me. I understand that I have the right to revoke consent at any time in writing.

CONSENT FOR RELEASE OF INFORMATION

I authorize the release of any information required by my insurance carrier, government agency, or any entity responsible for processing or paying my claims for medical benefits and such consent is valid for the life of the claim. I authorize information from my medical record to be reviewed by employees of my insurance company, their agents or my health care providers. I authorize Washougal Sport and Spine to release and receive a copy of my medical records to and from another health care provider to which I have been referred for the purpose of providing care. I understand that information from my medical record may be reviewed or released while I am receiving care or after discharge, and this information will be held confidential, except as allowed by law. I understand that a facsimile or photographic copy shall be as valid as the original.

RESPONSIBILITY FOR PERSONAL PROPERTY

I agree that Washougal Sport and Spine is not responsible for my personal items.

STATEMENT OF FINANCIAL RESPONSIBILITY

I understand that Washougal Sport and Spine Physical Therapy performs insurance billings and verification of benefits as a courtesy, but ultimate financial responsibility is mine, and I agree to pay for services rendered according to Washougal Sport and Spine's rates and terms. I understand I am responsible for charges not covered by my insurance or other agency, which may include a deductible, co-pay, and/or co-insurance within 30 days of receipt. I understand that balances outstanding greater than 90 days will incur a penalty and will accrue interest at the rate of 1% per month. Accounts may be turned over to a collection agency if remain unpaid. As a parent or legal guardian of a minor patient, I agree to pay in accordance with the terms and conditions set forth in this financial policy. As a self-paying patient, I understand that I am responsible for payment by personal check, credit card or cash at the time of service.

ASSIGNMENT OF INSURANCE BENEFITS

I authorize payment of all insurance or health plan benefits directly to Washougal Sport and Spine. If I am applying for payment under Medicare or Medicaid, I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for services rendered to Washougal Sport and Spine and authorize them to submit a claim to Medicare or Medicaid on my behalf. I am the patient, or I am authorized as the patient's agent to execute the terms of this document, or I assume individually all financial responsibility by signing below.

CANCELLATION POLICY

Patients who provide less than 24 hours notice of cancellation may be billed directly $40.00 for the first late cancellation.
Future late cancellations or no-shows may require full payment for the visit or $100.00. This is billed directly to you, not through your insurance. Patients who frequently fail to notify us of cancellation within 24 hours may be removed from the schedule.

I CERTIFY THAT I HAVE READ, FULLY UNDERSTAND, AND CONSENT TO THE TERMS SET FORTH IN THIS DOCUMENT. I ALSO CERTIFY THAT I RECEIVED THE NOTICE OF PATIENT PRIVACY PRACTICES AND I UNDERSTAND MY RIGHTS TO PRIVACY OF MY PERSONAL HEALTH INFORMATION AS DEFINED WITHIN THIS DOCUMENT

Patient name: _____
(please print)

Patient Signature: _____ Date: _____