Staszak Physical Therapy
& Wellness Center

488 E. 11th Ave., Suite 150A • Eugene, Oregon 97401
tel: 541.505.8180 • fax: 541.505.7134
staszakpt.com

Consent for Treatment and Authorization for Release of Information:

I, the patient, grant permission to the representatives of Staszak Physical Therapy & Wellness Center to perform all necessary procedures and treatments as prescribed by my physician. I understand that I may refuse treatment or terminate services at any time and the clinic may terminate their services to me.

Staszak Physical Therapy & Wellness Center may release information from my medical records to any health care provider involved in my care and treatment, and to any person or organization liable for all or part of my charges, such as my insurance carrier, any third-party payer, Medicare programs, and my employer's workers' compensation carrier. I acknowledge that upon the disclosure of medical record information to an insurance company or other payer pursuant to this authorization, Staszak Physical Therapy & Wellness Center is no longer responsible for the confidentiality of any information known or possessed by the payer.

Financial Agreement/Assignment of Benefits:

As courtesy to our patients, Staszak Physical Therapy and Wellness Center will file insurance claims to those carriers you have listed. In order to file claims on your behalf, it is important that you provide us with complete and accurate information. Please be advised that the representatives of Staszak Physical Therapy & Wellness Center may be familiar with your insurance benefits, but cannot define your insurance plan benefits, or any coverage that may or may not be available to you. If you have questions regarding your coverage and/or claims filed, we advise you to contact your insurance plan.

I, the patient, understand and agree that I am responsible for the guarantee of payment in full to Staszak Physical Therapy & Wellness Center for services and supplies, whether or not those services and supplies are covered by my medical insurance, worker's comp or motor vehicle claim, Medicare, Medicaid, or any other sources of payment.

I, the patient, understand that any co-pays, deductible and coinsurance dollars not yet satisfied, will be due on the date of each service prior to treatment. The representatives of Staszak Physical Therapy & Wellness Center will make every attempt to obtain this information accurately from your insurance carrier prior to your admission for treatment. If a parent or separate entity other than myself is represented as the guarantor/responsible party of my account and has not accompanied me to my appointment, I understand that I am still required to pay any deposits deemed due by Staszak Physical Therapy & Wellness Center on the date of my service. Any patients that are not prepared to make a deposit toward their **ESTIMATED** uninsured balance may be rescheduled upon the discretion of the therapist responsible for that day's treatment. Please note that any payments made on the date of services are considered a **DEPOSIT** toward your **ESTIMATED** patient balance. Patient balance still may be due upon receipt of response from your insurance carrier. The patient will then receive a monthly statement as defined in the following paragraph.

I, patient, understand that Staszak Physical Therapy and Wellness Center processes patient billings on a monthly basis. All unprocessed/unpaid insurance claims will be transferred to patient balances. Payment in full for balances on patient statement is due upon receipt of statement. Any payment for balance due not received within 30 days of date of the statement will be considered past due. There will be a $35.00 charge for all returned checks. All patient balances over 30 days will be assessed a 5% service charge (a $5.00 minimum).

No Show & Late Cancel Appointments For All Patients (Excluding Worker's Comp):

I, the patient, understand that Staszak Physical Therapy & Wellness Center has a 24-hour business day policy for cancellations and missed appointments. If I fail to arrive for my scheduled appointment or do not provide the 24-hour business day notice for cancellation of my appointment, Staszak Physical Therapy & Wellness Center will charge my account $50.00. This fee is strictly patient responsibility and will not be billed to any insurance plan. Upon the 3rd violation of this policy, the representatives of Staszak Physical Therapy & Wellness Center reserve the right to charge my account the full fee of a 60 minute appointment, and/or refer me back to my physician, and/or discharge me from their care. Payment for a missed appointment is due upon check in at my next visit.

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No Show & Late Cancel Appointments For Worker's Comp Patients:

I, the patient, understand that Staszak Physical Therapy & Wellness Center has a strict no show and late cancellation policy. Under Oregon Worker's Compensation Laws, providers are legally unable to charge me for no shows or late cancellations. Due to this factor, I will be given one chance. If I violate this policy, representatives of Staszak Physical Therapy & Wellness Center reserve the right to discharge me from their care and refer me back to my physician.

Signatures:

With my signature below I, the patient, understand, agree, and accept all conditions as noted in this document set forth by Staszak Physical Therapy & Wellness Center.

- I, the patient, request any payments on my behalf to be made to and sent directly to Staszak Physical Therapy & Wellness Center at 488 E. 11th Ave., Suite 150a, Eugene, OR 97401.
- I, the patient, authorize Staszak Physical Therapy and Wellness Center to furnish any and all information necessary to process insurance claims on my behalf.
- I, the patient, can at any time request a copy of this document. I understand that Staszak Physical Therapy & Wellness Center must retain the original, and any photo static copy of this document shall be considered effective and as valid as the original.
- In the event that my patient account is referred to an outside professional collection agency or attorney for collection, I, the patient, agree to pay any and all attorney fees, as well as any and all collection agency expenses associated with the collection of my account whether a suit is filed or not.
- I, the patient, hereby authorize Staszak Physical Therapy & Wellness Center to request and/or receive any and all medical records from my previous physician(s) regarding the treatment I am undergoing at Staszak Physical Therapy & Wellness Center.
- I understand that I have the right to review the Privacy Practices Document which is kept on file at Staszak Physical Therapy & Wellness Center.

By signing below, I confirm that I have read and agree to the above information.

______________________________	__________	______________________________	__________
Patient Signature (Age 18 and Over)	Date	Guarantor Signature	Date

______________________________	______________________________	______________________________
Printed Patient Name	Printed Guarantor Name	Relationship to Patient