Staszak Physical Therapy
& Wellness Center

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

PATIENT REGISTRATION

PATIENT INFORMATION

Name:_____ Nickname:_____ Date of Birth:_____ Sex: ____

Mailing Address:_____ City:_____ State:____ Zip Code: _____

Primary Phone #: _____ Secondary Phone#: _____ Email: _____

Referring Physician:_____ Primary Care Physician: _____

How did you hear about us? _____

RESPONSIBLE PARTY INFORMATION *(IF PATIENT IS UNDER 18 YEARS OLD)*

Guarantor Name:_____ Date of Birth:_____ Sex: _____

Mailing Address:_____ City:_____ State:____ Zip Code: _____

Primary Phone #:_____ Relationship to Patient: _____ Email:_____

PRIMARY INSURANCE INFORMATION

Name of Insurance Company:_____ Insurance Phone:_____

Subscriber Name: _____ Date of Birth:_____

Subscriber ID:_____ Group #:_____

SECONDARY INSURANCE INFORMATION

Name of Insurance Company:_____ Insurance Phone:_____

Subscriber Name: _____ Date of Birth:_____

Subscriber ID:_____ Group #:_____

MVA/WORKER'S COMP INSURANCE INFORMATION

Name of MVA/WC Insurance:_____ Claim #:_____

Adjuster:_____ Phone # & Ext.:_____

Date of Injury:_____State:_____ Employer: _____

Employer Address and Phone #_____

I certify that the above information is true and correct to the best of my knowledge. I authorize Staszak Physical Therapy & Wellness Center to furnish any and all insurance information necessary to process all claims and agree to the assignment of insurance benefits to them.

_____ _____ _____ _____

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

_____ _____ _____

Printed Patient Name Printed Guarantor Name Relationship to Patient

Updated February 16, 2022

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No Show and Late Cancellation Policy

I 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 on Tuesday-Saturday and by 12pm on Saturday for a Monday appointment, I will be charged a **$50.00 fee**. If I am scheduled for both physical therapy and a second service, I will be charged an **$80.00 fee**. This fee is strictly patient responsibility and will not be billed to any insurance plan. Upon the 3rd violation of this policy, the Staszak Physical Therapy & Wellness Center reserves the right to charge me the full fee of a full 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**.

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

_____ _____

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_____ _____ _____

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Financial Agreement/Assignment of Benefits:

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

I 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, or any other sources of payment. I understand that any co-pays, deductible and coinsurance dollars not yet satisfied, will be **due at the time of service**. The representatives of Staszak Physical Therapy & Wellness Center will make every attempt to obtain this information accurately from my insurance carrier prior to my 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 payments due on the date of my appointment. I am aware that any payments made on the date of services are considered a **DEPOSIT** toward the **ESTIMATED** patient balance. Additional patient balance may still be due upon response from the insurance carrier. I will then receive a monthly statement as defined in the following paragraph. After I am discharged from therapy, if there is a credit on my account, a refund check will be mailed to me.

I understand that Staszak Physical Therapy and Wellness Center processes patient billings on a monthly basis. 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). Any unpaid patient balance more than 90-days past due may be referred to an outside collections agency.

I consent to receive monthly patient billings via email to: _____
If I change my email address, I agree to update Staszak Physical Therapy with the new address. I understand I am still responsible for the balance owed for any bill(s) sent to an email address that I have not updated.

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

_____ _____

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Consent for Treatment and Authorization for Release of Information:

I 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 outside entity pursuant to this authorization, Staszak Physical Therapy & Wellness Center is no longer responsible for the confidentiality of that information.

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
* 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, will be given 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, the patient, understand that I have the right to review the Privacy Practices Document which is kept on file at Staszak Physical Therapy & Wellness Center.
* I authorize Staszak Physical Therapy & Wellness Center to contact me via the above listed email for periodic newsletters and promotional specials.

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

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