Staszak Physical Therapy
& Wellness Center

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

PATIENT REGISTRATION

PATIENT INFORMATION

Name:_____________________________________ Nickname:____________ Date of Birth:___________ Sex: M / F

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: M / F

Mailing Address:________________________________ City:_______________ State:____ Zip Code: _________

Primary Phone #:_______________ Secondary Phone#: _______________ Email:______________________

Employer Name:____

I certify that the above information is true and correct to the best of my knowledge. I acknowledge, by signing below, that I accept the terms and agreements stated below. I authorize Staszak Physical Therapy & Wellness Center to contact me via the above listed email for periodic newsletters and promotional specials.

Pricing: The physical therapy evaluation is $130.00 and due at time of service. Follow-up physical therapy visits are $100.00 and due at time of service.

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.

Charge for No Show/Cancellation without 24 hour notice: 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, I will be charged $50.00. If I am scheduled for both physical therapy and a second service, I will be charged an $80.00 fee. Upon the 3rd violation of this policy, the representatives of Staszak Physical Therapy & Wellness Center reserve the right to charge me the full fee of an 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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Financial Agreement: I understand that there is no guarantee of payment from any insurance company or other payer. Either I do not have personal health insurance coverage, or I am foregoing the option of billing my personal health insurance carrier. I hereby release Staszak Physical Therapy & Wellness Center from billing my personal health insurance carrier for any and all dates of service related to this course of physical therapy treatments. I understand that any payments made to Staszak Physical Therapy & Wellness Center are not credited towards my personal health insurance deductible, and that Staszak Physical Therapy & Wellness Center will not retro-bill previous dates of service. I agree to pre-pay all charges for the services provided by Staszak Physical Therapy & Wellness Center upon check-in to my appointment. I understand that I am responsible for a $35.00 returned check fee in addition to any other associated bank charges.

- 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.
- 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

Updated March 7, 2019