ELEVATE
PHYSICAL THERAPY
FITNESS AND PERFORMANCE

2312 South Sixth Street Suite B
Klamath Falls, OR 97601

(541) 887-2030 office
(541) 887-2070 fax

Patient Name _____ Date _____

Medical Power of Attorney/Legal Guardian Name _____

FINANCIAL RESPONSIBILITY

You hereby authorize payment to be made directly to ELEVATE Physical Therapy Fitness and Performance for services rendered. You hereby authorize ELEVATE Physical Therapy Fitness and Performance to release (or obtain) information regarding your physical therapy evaluation and treatment and related billing information to (from) your attorney, or insurance carrier for purposes of processing this claim. You understand that you will be responsible for any copay or deductible as defined by your insurer. The remaining account balance will become due upon completion of care according to the terms of repayment. You agree to pay any charges incurred for bounced checks, collection, court and attorney fees.

You are responsible for contacting your insurance company to find out if they need a referral or authorizations in order for your PT treatment to be covered. In the case that you fail to obtain the necessary authorization you will be responsible for payment.

It is your responsibility to contact your insurance company to inquire about the out of pocket expenses you might incur due to PT treatment. **The amount quoted by the staff at ELEVATE Physical Therapy Fitness and Performance is just an estimate based on the type of insurance plan, not a guarantee of benefits or a definitive representation of the cost of services**. You must call your insurance company to see if a copayment or deductible apply. Any out of pocket expenses incurred, based on your insurance contract, will be your responsibility regardless of whether they were aware of the cost prior to treatment.

Some plans have co-payments, co-insurance or deductibles, while others have a combination of these. There are also restrictions on the number of visits permitted by the various plans. It is your responsibility to understand the requirements of your particular plan. We will work with you to clarify any questions that we are able.

Any visits that are not covered under your insurance plan will be billed to you at our "payment at time of service" fee of $135 for an evaluation and $90 per follow up visit(s). These prices are subject to change. You will be notified if these prices are changed.

If your insurance requires you to pay a large sum out of pocket and you are having trouble understanding your balance, you can contact our office and we will be happy to go over the expenses with you. If you are unable to pay the balance in full, we will exercise reasonable efforts to work out a payment plan with you.

PATIENT INITIALS ____
INITIALS OF MEDICAL POWER OF ATTORNEY OR LEGAL GUARDIAN _____

CONSENT TO RECEIVE SERVICES

You hereby authorize the physical therapy staff to administer treatment as they deem necessary. I also certify that no guarantee or assurance has been made to the results that may be obtained. I recognize and agree that I have the right to refuse treatment or terminate services at any time. Upon the start of your treatment, we will inform you of the specific treatment that will be undertaken, any alternative forms of treatment available, and any risks inherent with the chosen treatment. After this explanation, you will have the opportunity to ask questions regarding the specific treatment.

PATIENT INITIALS _____
INITIALS OF MEDICAL POWER OF ATTORNEY OR LEGAL GUARDIAN _____

AUTHORIZATION FOR EMERGENCY MEDICAL SERVICES

At any time while receiving services from ELEVATE Physical Therapy Fitness and Performance and in the event of any medical emergency, you authorize ELEVATE Physical Therapy Fitness and Performance or its employees / contractors to provide or obtain such medical treatment as they deem advisable under the circumstances of the particular medical emergency, and I agree to assume sole responsibility for all charges for such treatment. You agree to notify ELEVATE Physical Therapy Fitness and Performance of your code status prior to being treated at ELEVATE Physical Therapy Fitness and Performance.

PATIENT INITIALS _____
INITIALS OF MEDICAL POWER OF ATTORNEY OR LEGAL GUARDIAN _____

MEDICARE/MEDICAID PAYMENT AUTHORIZATION

If a Medicare or Medicaid patient, you certify that the information you have provided to ELEAVTE Physical Therapy Fitness and Performance to apply for payment under Title XVIII or Title XIX of the Social Security Act is correct. You request that payment of authorized benefits be made to ELEVATE Physical Therapy Fitness and Performance on your behalf.

PATIENT INITIALS ____
INITIALS OF MEDICAL POWER OF ATTORNEY OR LEGAL GUARDIAN _____

AUTHORIZATION TO USE RECORDING DEVICES

In conjunction with your care, you authorize the use of recording devices, including, without limitation, a camera and/or mobile device to record videos and/or images for the purposes of enhancing your care. In addition, you authorize the transmittal of such recording device videos and/or images to your rehabilitation provider and/or the treating physician through secure means. You acknowledge that such videos and/or images will only be used or disclosed for treatment purposes or health care operations purposes, and that your rehabilitation provider will not further use or disclose such videos and/or images for any other purpose without your written authorization.

PATIENT INITIALS _____
INITIALS OF MEDICAL POWER OF ATTORNEY OR LEGAL GUARDIAN _____

RELEASE OF MEDICAL RECORDS

You hereby consent and request that copies of your therapy treatment records be provided to:

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For the period of your current start of care date to discharge date.

PATIENT INITIALS _____
INITIALS OF MEDICAL POWER OF ATTORNEY OR LEGAL GUARDIAN _____

ACKNOWLEDGEMENT OF RECEIPT

You acknowledge that you received a copy of ELEVATE Physical Therapy Fitness and Performance Notice of Privacy Practices. You understand that this document provides an explanation of the ways in which your health information may be used or disclosed by ELEVATE Physical Therapy Fitness and Performance and of your rights with respect to your health information. You have been provided with the opportunity to discuss concerns you may have regarding the privacy of your health information.

PATIENT INITIALS _____
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_____	_____	_____
PATIENT NAME (Printed)	PATIENT SIGNATURE	DATE
_____	_____	_____
PARENT/GUARDIAN NAME (Printed)	PARENT/GUARDIAN SIGNATURE	RELATIONSHIP