971 NW Spruce Ave Ste 101 Corvallis, OR 97330 phone: (541)207-3436 fax: (541)207-3284

PATIENT GUIDELINES AND CONSENT FOR TREATMENT

Welcome to Sweetgrass Physical Therapy & Wellness! In order to receive the maximum benefit from your rehabilitation program, it is of utmost importance that you attend your therapy appointments consistently. You are expected to participate in the home exercise program and self-management procedures recommended by your therapist.

Cancellation and No-Show Policy: If you are unable to keep your appointment, please notify our office so that your treatment can be rescheduled. 24 hours notice is appreciated as it may allow another patient to be scheduled at that time. We have a confidential voice mail to answer your call 24 hours per day. If you do not show for your appointment and do not call to cancel, we reserve the right to remove you from the schedule until you contact us to reschedule. Repeated no shows are grounds for discharge from therapy services.

Consent for Treatment: I authorize the staff of Sweetgrass Physical Therapy & Wellness LLC to undertake such treatments and procedures as deemed appropriate to improve my condition. I will participate in the formulation of my treatment plan and recognize I have the right to refuse treatment. After proper evaluation procedures have been completed, I will have the opportunity to discuss with the therapist the risks and benefits of participating in the therapy program versus not receiving treatment as indicated by the therapist.

Authorization for Release of Information: I agree that Sweetgrass Physical Therapy & Wellness LLC may provide information from my medical record to persons involved in my medical care. I authorize the release of medical information necessary to obtain payment of any benefits available to me to Sweetgrass Physical Therapy & Wellness LLC for services rendered. I agree that Sweetgrass Physical Therapy & Wellness LLC may obtain information from others who have provided medical care to me and/or are responsible for the payment of all or part of my bills when this information is needed in order to treat, bill, and/or receive payment.

____ I hereby acknowledge that I have received a copy of Sweetgrass Physical Therapy & Wellness LLC Notice of Privacy Practices. I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the clinic is not required to agree to the request.

Assignment of Insurance Benefits: I authorize payment of medical benefits available to me through Medicare, Medicaid, or any other third party payor be made on my behalf directly to Sweetgrass Physical Therapy & Wellness LLC for physical therapy services rendered. I understand and I agree I am financially responsible to Sweetgrass Physical Therapy & Wellness LLC for charges not paid by this assignment. I will assist in the collection of my insurance should there be any delay in payment.

Financial Consent: I agree to pay Sweetgrass Physical Therapy & Wellness LLC charges for all services rendered to me during my course of treatment. I agree to pay those charges which may not be paid by my health insurance and are my responsibility per my insurance benefit. I agree to pay a per annum fee of 18% of any balance more than 30 days past due. I agree to pay Sweetgrass Physical Therapy & Wellness LLC collections costs including attorney and court fees associated with the collection of past due balances. I agree to pay a $35 fee for each and every returned check. I agree to pay a 2.9% service charge for any balance paid in person by credit card. I agree to pay a 3.5% service charge if paying any balance by credit card over the phone, by mail or online. If I have included a cell phone number in my contacts, I hereby give permission for the office or assignee to call or text that phone.

Medicare and Medicaid Patients: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is true and correct.

This document shall remain valid for the entire episode of care for which you are seeking treatment.

Patient/Representative Signature: _____ Date: ___/___/20____

Relationship to patient: _____ **Witness:**_____