NOTICE AND AGREEMENT

To Our Patient's:

We are happy to have you as a new patient. As you know, your physician has determined that physical therapy treatments is necessary and appropriate for your condition and has referred you to obtain services. We are glad you have selected our clinic for your care.

In many cases, your insurance will pay for part of substantially all of your physical therapy care. We will work with you to ensure your insurance carrier, whether a medical care insurer or a motor vehicle accident insurer, receives all documentation needed to process and pay your claim.

However, our relationship is with you as our patient and not with your insurance company. Because you are receiving the services, you have the final responsibility to pay for those services. If your insurer fails to pay the full amount of our bill for services, after accounting for any applicable deductible amount, co-payment amount or hold-harmless amount, you will be required to pay the difference.

Except for Medicare, we do not bill secondary insurances unless prior arrangements are made with the billing office.

Our bill is due in full when received. If you fail to pay in full and we are required to re-bill you after the 15th day of the month following the month you receive your bill, you will be charged a re-billing fee of $3.00 per month.

If you are receiving treatment as the result of a motor vehicle accident, you are responsible for paying all costs of treatment not reimbursed by the Personal Injury Protection (PIP) coverage under a motor vehicle insurance policy or other insurance policy. If your motor vehicle accident claim is in dispute and there is no insurance coverage for your treatments, we may agree to accept regular monthly payments on your account. In this event, unpaid balances on your account will carry a late payment charge of $3.00 per month. If you fail to make the agreed upon monthly payment, we may declare the entire amount of the bill due immediately. In some cases, your insurance company may issue payments directly to you. These checks must be endorsed and immediately forwarded to the billing office for processing.

Please note that in the event that you fail to make payment when due, this account will be referred to a collection agency for collection. In that event, a contingency fee of 40% will be added to the principal and interest due by the collection company. You will be additionally liable for attorney fees. Both collection agency fees and attorney fees will increase the balance you owe.

AGREED: _____

Patient's/Guardian's Signature Date

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Print Patients Name

WORKMAN'S COMP NOTICE AND AGREEMENT

To Our Worker's Compensation Patient's:

We are happy to have you as a new patient. As you know, your physician has determined that physical therapy treatment is medically necessary and appropriate for your condition and has given you the legally required referral to obtain services. We are glad you have selected our clinic for your care.

We understand that you have filed, or are in the process of filing a claim for worker's compensation insurance coverage for your injury and treatment. If your claim is denied or if it is in dispute, we will bill your regular medical insurance carrier, pursuant to ORS 656.313, for the cost of your care, excluding any applicable deductible or co-payment amounts. While your claim is in dispute, you are not required to pay any deductible or co-payment to this clinic.

Should your claim be in litigation and you later settle your claim and receive a dispute claim settlement, we require payment in full 10 days after disbursement.

If your claim is later resolved against you, you are required to pay any deductible or co-payment not covered by your medical insurance. If you do not have regular medical insurance, you are personally responsible for the cost of treatment. (Please let us know if this is the case and we will make a special effort to accommodate your needs). Payments not received by the 15th of the month are subject to a $3.00 per month re-billing fee.

Please note that in the event that you fail to make payment when due, this account will be referred to a collection agency for collection. In that event, a contingency fee of 40% will be added to the principal and interest due by the collection company. You will be additionally liable for attorney fees. Both collection agency fees and attorney fees will increase the balance you owe.

AGREED: _____

Patient's Signature Date

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Print Patients Name