CLACKAMAS PHYSICAL THERAPY ASSOCIATES, INC.

"Putting your life back in motion"

FINANCIAL AGREEMENT
PLEASE READ CAREFULLY

1) As a service to you, this office will bill your insurance company. We ask that all insurance companies pay us directly.

2) I authorize _____ Insurance Company to make payments directly to **Clackamas Physical Therapy Associates, Inc.** If my current policy prohibits direct payment, I hereby instruct and direct my insurance company to make the check to me and will then pay **Clackamas Physical Therapy Associates, Inc.** directly.

3) I understand that as the patient or guardian I am responsible for all charges whether or not paid by insurance.

4) Payment is expected within 30 days after the first statement is sent and is considered past due if a second statement is sent. Balances older than 60 days are subject to additional collection fees and interest charges of 1.5% per month.

5) **IT IS IMPORTANT THAT YOUR APPOINTMENTS BE KEPT.** We ask that at least 24-hours notice be given if you cannot keep your appointment. There is a $50.00 service charge for an appointment missed without notice.

6) If the patient is a minor, a parent or guardian must be present at the first visit to sign treatment authorization and payment agreement forms before the patient can be seen.

I HAVE READ THE ABOVE PAYMENT POLICIES AND AGREE TO THE TERMS OF THESE POLICIES. IN THE EVENT LEGAL ACTION SHOULD BECOME NECESSARY TO ENFORCE PAYMENT OF ANY CHARGES, I AGREE TO BE RESPONSIBLE FOR AND PAY ALL ATTORNEY'S FEES AND COURT COSTS INCURRED.

CONSENT TO TREAT

I authorize **CLACKAMAS PHYSICAL THERAPY ASSOCIATES, INC.** to provide physical therapy services to myself or my dependent. I further authorize **CLACKAMAS PHYSICAL THERAPY ASSOCIATES, INC.** to release any information in the course of my examination or treatment to my physician, insurance company, lawyer, or other allied health professionals.

SIGNED: _____ DATE: _____

Patient or Guardian

WITNESS SIGNATURE: _____