



Confidential Patient Information

1720 SE Haig St
Portland, OR 97202
Phone: (305)979-9836
www.fuerzapt.com

Name				DOB	-	-	Age	
Address	Apt			Phone	-	-		
City	State	Zip	Gender	<input type="checkbox"/> Male	<input type="checkbox"/> Female			
Permanent Address				Phone	-	-		
City	State	Zip	E-Mail					
Social Security #	-	-	D/L #				State	
<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Widowed	<input type="checkbox"/> Divorced	<input type="checkbox"/> Separated				
If a minor, parent / guardian name								
Social Security #	-	-	DOB	-	-			
Employer				Phone	-	-		
Address				Ext or Dept				
City	State	Zip	Hours					
Occupation				Supervisor				
Spouse				DOB	-	-	Age	
Social Security #	-	-	Phone	-	-			
Employer				Work	-	-		
Address								
City	State	Zip						
Emergency Contact				Relationship				
Address				Phone	-	-		
City	State	Zip						
Referring Physician				Next Visit				
Primary Care Physician				Next Visit				

I hereby authorize the release of any medical information necessary for processing insurance claims and payment of medical benefits for myself or the party who accepts assignment of benefits.

Signature _____ **Date** _____



Patient Privacy Policy & Procedure Statement

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Dear Patient:

Fuerza Physical Therapy maintains compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy regulations passed into law on December 20, 2000.

We obtain your voluntary consent to provide treatment, release medical records to the appropriate entities and those who you designate to provide health care treatment, payment, and daily operations of the facility.

Our clinical and front office staff uses patient information to ensure quality care and appropriate billing for services.

You may correct, amend, access, and request a copy of your medical record and access history by signing a letter for release of your medical information. The cost for copies of medical records is in accordance with state law.

We protect all patient information within the guidelines provided by federal, state, and local government.

If you have any grievance pertaining to the privacy of medical records or wish to inquire further about how our facility manages patient information, please contact our Privacy Officer at 305-979-9836.

Fuerza Physical Therapy reserves the right to amend, change, and/or revise our privacy policy at any time in accordance with federal, state, and local rules, regulations, and guidelines.

Thank you for choosing our health care facility.

Signature

Patient / Guardian

Date



Consent for Care and Treatment

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I, the undersigned, do hereby agree and give my consent for Fuerza Physical Therapy to furnish medical care and treatment to _____ which is considered necessary and proper in the diagnosing or treating of my (their) physical condition.

Signature _____ Date _____
Patient / Guardian

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I, the undersigned, hereby assign all medical benefits, ie.: Medicare, private insurance, major medical benefits, Workers' Compensation and any other health plans to which I am entitled to Fuerza Physical Therapy. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize Fuerza Physical Therapy to release all medical information and records necessary to secure payment for services rendered.

Signature _____ Date _____
Patient / Guardian

FINANCIAL POLICY STATEMENT

It is our policy to bill your insurance carrier or other provider of medical benefits as a courtesy to you, although you are responsible for the entire bill when the services are rendered. Required co-payments and estimated co-insurances are to be made as services are rendered and arrangements are to be made for payment of all amounts not covered by your medical benefits or estimated co-insurances as soon as those amounts are known. If your medical benefits are not paid within sixty (60) days, the balance will be due in full from you.

All co-insurance percentages paid at time of service are estimated. Your actual liability may be more. You are responsible for any difference between the estimated and actual co-insurance due.

If any payments of medical benefits are made directly to you for services rendered by Fuerza Physical Therapy, you must promptly remit such payment directly to Fuerza Physical Therapy.

If you are a Workers' Compensation patient the above policy does not apply to you. Be advised, however, that you may be responsible for your charges if your Workers' Compensation claim is successfully controverted.

If you fail to make timely payment for any amount for which you are responsible, you will be responsible for all costs of collection, including court costs, collection agency fees and/or a reasonable attorney fee.

I have read the above information and/or it has been explained to me and I accept the terms and conditions of the above and will be responsible for the payment of my account.

Signature _____ Date _____
Patient / Guardian