Go! PT
1000 River Road
Eugene, Oregon 97404

Personal Information – Please Print

Today's Date_____

Name_____ Date of Birth_____ Age _____

Address_____ City_____ State_____ Zip_____

Cell Phone (_____)_____-_____ Text Message Reminders? Yes / No (please circle)

Home Phone (_____)_____-_____ Work Phone (_____)_____-_____

Email Address _____ Preferred Pronouns_____ Sex_____

Primary Contact Number (circle one) Cell Home Work

Occupation/Job_____

Employer_____

Marital Status ( )Married ( )Single( )Divorced ( )Widowed ( )Partnered

Spouse/Partner Name_____ Their Employer_____

Their Phone Number (_____)_____-_____

Other Responsible Party (if Applicable)_____

Nearest relative not living with you_____

Address and Phone #_____

Nearest friend not living with you_____

Who referred you to us?_____

Referring Physician_____

Address and Phone #_____

Primary Physician_____

Address and Phone #_____

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Medical Insurance

Name_____ Date of Birth_____ Date_____

Primary Insurance to be billed_____

ID #_____ Effective Date_____

Insurance Address (on ID card)_____

Provider phone # (on back of card) (_____)_____-_____

Name of Insured_____

Relationship to Insured (circle one) Self Spouse/Partner Child Other

Secondary Insurance to be billed_____

ID #_____ Effective Date_____

Insurance Address (on ID card)_____

Provider phone # (on back of card) (_____)_____-_____

Name of Insured_____

Relationship to Insured (circle one) Self Spouse/Partner Child Other

Accident Insurance

Accident Information (circle one) None Auto Work Other

Date of Accident/Onset of Symptoms_____ Symptoms_____

_____

Insurance Company_____

Address_____

Phone #_____ Claim#_____

Adjuster Name and Phone #_____Ext_____

Do you have an attorney involved (circle one) Yes / No Name_____ Phone #_____Ext_____

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Financial Policy

In the interest of good health care practice, it is desirable to establish a policy to avoid misunderstandings. Our primary responsibility is to help patients experience good health and we wish to spend our time and energy toward that end. Therefore, we would like you to know about our financial policy.

- Payment is due and payable at the time of your visit.
- All supplies must be paid for as you take them.
- We accept cash, checks, credit, and debit cards. We do NOT accept American Express.

SELF PAY PATIENTS: If you are paying for services at the time of visit and our office is not involved in billing your insurance company, filling out forms, or waiting payment we do offer a bookkeeping discount.

MEDICAL INSURANCE: As a courtesy to our patients, we will bill your primary insurance carrier (We do not bill secondary companies except for Medicare patients). Co-payments, deductibles, and percentages that are patient responsibility are due at the time of service. By signing this form, you are authorizing the release of your records to facilitate claims processing and for continuity of care. You are also authorizing that any payments be made directly to Go! Physical Therapy.

PERSONAL INJURY/AUTO INSURANCE: Regardless of who the responsible party is, a claim will be established with your auto insurance company. Please contact your agent, inform them of your care and request forms to set up a claim. You are still personally responsible for your bill, but you will not be required to pay as services are rendered. If your balance reaches $800 and your insurance company is withholding payment for any reason, we can bill your private insurance, or you may be required to pay out of pocket: we do not hold balances above $800. We require that you sign a lien form assigning payment to Go! Physical Therapy from an insurance company, or from an attorney, in case one should become necessary.

WORKERS COMPENSATION: You are not personally responsible for the account unless your claim is partially or totally denied by Workers Compensation Insurance. At that point, we can bill your private insurance company if you have physical therapy benefits with that company.

Thank you for taking time to read this financial policy. If you have questions at all, please do not hesitate to ask the staff.

Please not that we do charge a fee of $50 for late cancelations and no-shows. If you need to cancel your appointment we ask to be notified 24 hours in advance barring unforeseen emergency circumstances. Thank you for understanding.

I have read and understand the financial policy above and agree to pay when necessary, according to the above policy.

Signature_____Date_____

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Patient Informed Consent Form

Medical doctors, chiropractic doctors, physical therapists, and osteopaths that perform manipulation are required by law to obtain informed consent before starting treatment.

I,_____, consent to examination and to the performance of conservative noninvasive treatments for my condition, by Eric Ottenbreit and his assistant Nakia Keim. I understand that the procedures may consist of manipulations involving movement of my joints and soft tissues, along with physical therapy modalities, rehabilitative exercises, x-rays-K-laser, electric therapies, and nutraceuticals.

I am aware that as with any form of therapy, there are possible risks and complications associated with common physical therapy procedures, which are as follows.

- Soreness: I am aware that like exercise it is common to experience muscle soreness after a few treatments.
- Dizziness: temporary symptoms like dizziness and nausea can occur but are relatively rare.
- Joint injuries: I understand that in isolated cases, underlying physical defects, deformities of pathologies like weak bones from osteoporosis may render that patient susceptible to injury. When osteoporosis, discal degeneration, or other abnormalities are detected, extra caution will be employed.
- Physical Therapy burns: Some of the therapies used in this office generate heat and may rarely cause burns. Despite precautions, if a burn is obtained, there will be a temporary increase of pain and possible blistering. This should be reported to the doctor.

Tests will be performed on me prior to treatments to minimize the risks of these or any other complication from treatment, and I freely assume these risks. I also understand that there are beneficial effects associated with these treatment procedures including decreased, pain, reduced muscle spam, increased mobility, and improved neurological function. However, I appreciate that there is no certainty that I will achieve these benefits. I realize that the practice of all forms of medicine, including Physical Therapy, is not an exact science, and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.

I have read or have had read to me the above explanation of physical Therapy treatment. Any questions I have regarding these procedures or alternative treatments available have been answered to my satisfaction prior to my signing this consent form. I have made my decision voluntarily and freely.

Patient Signature_____ Date_____

Doctor/Witness Signature_____ Date_____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ (Patient Name) acknowledge that I have received, reviewed, understand, and agree to the Notice of Privacy Practices of Go! Physical Therapy which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received, or maintained by the Practice.

Signature_____

Print Name_____ Date_____