

Healing Pathway Physical Therapy and Bodywork Patient Waiver

PERSONAL HEALTH INFORMATION

Your personal health information, which includes your entire medical history and information about services provided to you, is protected by law. This health record serves as a basis for planning your treatment, communication between your health care professionals, legal documentation, verification of treatment for third party payers, and a tool to improve your care based on outcomes. Although this record is the physical property of the health care provider, this information also belongs to you and you have rights regarding the privacy of your records. *A detailed explanation of these rights is available at the front desk of Portland Natural Health and a copy is available to you upon request.*

In order to provide the best care possible, we may need to discuss your case with other health care professionals and health care facilities. *By signing below, I authorize* Portland Natural Health/ Healing Pathway PT to release my medical records to my physician and my other health care professionals. *I also authorize* Portland Natural Health/ Healing Pathway PT to request pertinent medical records from these professionals (including copies of related imaging.)

Please list pertinent health professionals and their contact information:

I understand that my health information may include information both created and received by the clinic, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information. By signing below, I agree that I have been informed about this privacy practice and my protected health information and how to obtain a personal copy of this form and privacy policy.

Signature _____ **Date** _____

CONSENT TO TREAT

You are an important partner in your health care decisions and play an active role in the outcome of your medical care. Thus, it is important that you are informed about benefits, risks, evaluations, and decisions about your care while being seen at this office. If you have questions, symptoms, or problems related to your care it is your responsibility to notice your physical therapist and consult with your primary care provider as necessary.

By signing below, I agree to be treated by Healing Pathway Physical Therapy, knowing there may be potential risks along with benefits, and I am willing to be an active participant in my own care

Signature _____ **Date** _____

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CREDIT AND PAYMENT POLICIES

Our goal is to provide you with the highest quality care at a reasonable/reduced cost compared with many clinics. Your estimated financial responsibility will be assessed at the time of check-in and payment will be collected accordingly. ***For patients utilizing insurance, co-payments and estimated co-insurance for the day's treatment will be collected when you check-in for your appointment.*** Your insurance contract is between you and your carrier. As a courtesy to you, we will submit claims to most carriers. However, it is your responsibility to pay the required co-payments, deductibles, or uninsured amounts at the time of service. ***Self-pay patients will be expected to pay for services in full at the conclusion of their appointment*** (a discount is offered to these patients not billing insurance.)

Signature_____Date_____

PATIENT MISSED APPOINTMENT POLICY

We are committed to fully assist you with your rehabilitation needs and thus, you are expected to attend all of your appointments. We are reserving this time specifically for You. If you need to cancel or reschedule an appointment, please do so 24-hours prior to your appointment time. **A \$25 fee will be charged for sessions missed without such prior notification.** *This fee will be due prior to your next treatment* (insurance is not responsible for this fee.) All cancellations and no shows are documented in your medical record. We understand there are occasional emergency situations and we appreciate your consideration our time. In instances of repeated non-compliance with scheduled visits, we reserve the right to discontinue care. By signing below, you agree to this policy.

Signature_____Date_____