San Juan Physical Therapy (SJPT)
PO Box 1845 / 689-A Airport Center Road, Friday Harbor WA 98250
Phone 360.378.4112 / Fax 360.378.4655
sjpt4112@gmail.com

IN CASE OF EMERGENCY

Contact: _____ Phone #:_____
Relationship: _____ Alternate #: _____

CONSENT FOR CARE & TREATMENT

I understand that by signing my name below, I hereby agree and give my consent for medical treatment to be provided by SJPT for treatment of (diagnosis) :_____Date of Onset: _____

Initials: _____

INSURANCE BILLING & FINANCIAL RESPONSIBILITY

I understand that by signing my name below, I hereby agree and give my consent for SJPT to bill, to release any information necessary to secure payment, and to accept payment from my health insurance or a third-party payor such as Labor & Industries.

I understand that I am responsible for, and agree to promptly pay SJPT any balance which is not covered by or is denied by my insurance or a third-party payor. This includes, but is not limited to; co-payments, co-insurance, deductibles, plan exclusions, or lack of coverage.

Initials: _____

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Notice of Privacy Practices, and that I have been provided the opportunity to review it and to ask questions.

I authorize SJPT to communicate with me at the following address e-mail address:_____

Initials: _____

SIGNATURE of ACKNOWLEDGEMENT & CONSENT

By my signature below I acknowledge that I have read, understand, and agree to the terms and conditions of CARE & TREATMENT, BILLING & FINANCIAL RESPONSIBILITY, and PRIVACY PRACTICES contained in this document. A photocopy of this authorization shall be considered as valid as the original.

Patient Name: _____ Date: _____
Please Print

SIGNATURE _____ Relationship: _____
Of Patient or Guardian/Responsible Party

Please select how you would like to receive AUTOMATED APPOINTMENT REMINDERS

- ☐ Cell Phone (Circle one) TEXT or VOICEMAIL - Phone#_____
- ☐ Home Phone VOICEMAIL – Phone #_____
- ☐ NONE. I do not wish to receive appointment reminders