HILARY GARRETT, MS PT
FemFocus Physical Therapy

2190 NE Professional Ct.
BEND, OR 97701
541.385.7629

PATIENT INFORMATION

DATE_____ **BIRTHDATE**_____

NAME_____**MALE**___**FEMALE**___
Last First Middle Initial
ADDRESS_____**CITY**_____ **STATE**_____

ZIP_____ **HOME PHONE**_____**WORK/CELL PHONE**_____

SOC SECURITY#_____ **MARITAL STATUS**_____ **E-MAIL**_____

EMERGENCY CONTACT/TELEPHONE_____

NAME OF EMPLOYER_____**JOB TITLE**_____

EMPLOYER'S ADDRESS_____

REFERRING DOCTOR_____**DATE OF INJURY**_____

REASON FOR YOUR VISIT _____

BIRTHDATE OF PRIMARY INSURED FAMILY MEMBER_____

INSURANCE_____**NAME OF INSURED**_____

INS. BILLING ADDRESS_____
Street City State Zip
TELEPHONE_____**CONTACT PERSON**_____

CLAIM/ID#_____**GROUP #**_____

SUPPLEMENTAL INSURANCE_____**NAME OF INSURED**_____

BILLING ADDRESS_____

TELEPHONE_____**ID#**_____**GROUP#**_____

CONSENT FOR SERVICES/INFORMATION: I voluntarily consent to physical therapy services rendered by Hilary Garrett, as ordered by my physician and physical therapist. I understand that I will be informed of all proposed medical procedures or treatment prior to commencement. I also understand that I have the right to refuse any proposed medical procedure or treatment. I authorize Hilary Garrett to release medical records to my physician and/or insurers.

ASSIGNMENT OF INSURANCE: I authorize direct payment of medical benefits to Hilary Garrett. However, I fully understand that I am financially responsible to Hilary Garrett for all therapy services regardless of the insurance or other third-party coverage. A $25.00 fee for missing or canceling an appointment without 24-hour notice may be assessed. A rebilling fee will be assessed at a rate of $10 per month on accounts over 60 days. Accounts assigned to an outside collections agency will be charged a $25.00 collection fee.

SIGNED_____**DATE**_____