Payment Policy and Consent to Treat for Medicaid Patients requesting to pay for services

Self pay / Time of Service for Physical Therapy (OHP is not be billed as primary or secondary)

- I have requested to privately pay for physical therapy services
- The service being provided is a covered service by Oregon Health Plan. The requested treatment would be fully covered billed to Oregon Health Plan
- Appointments are scheduled for 1 hour.
- Self pay / Time of Service rate is $130.00.
- Payment is due at the time of service.
- If OHP is secondary insurance, I will be responsible for copays and deductibles as outlined by my primary insurer
- I have had the opportunity to ask questions, obtain additional information and consult with my caseworker or representative.
- I agree to the clinic Cancellation/No Show policy and its associated fees and have been provided a copy of the policy
- Patient cannot self submit claims to OHP for reimbursement

I understand that I am financially responsible for all charges. If my account becomes delinquent (over 90 days past due) and is therein default, I accept responsibility for the principal amount owing as well as all reasonable costs associated with the collection of this debt. This includes but is not limited to collection service fees of $20.00 per balance transferred, attorney's fee, and all court costs including additional legal fees associated with the recovery of this debt. I understand that there is a fee for all returned checks as allowed by state law. I do hereby consent to such treatment by the authorized personnel of Good Health Physical Therapy & Wellness as may be dictated by prudent medical practice by my illness, injury, or condition. This consent is intended as a waiver of liability for such treatment exception acts of negligence

Privacy Practices: A copy of HIPAA policy & procedures have been provided

Cancellation/No Show/Late Arrival Policy: Cancellation of a one hour appointment requires 24 hours prior notice. If an appointment is on a Monday, cancellation notice must be given on the Friday prior.
Please see our full posted Cancellation, No Show, and Late Arrival Policy that includes associated fees. A copy of the policy for your records has been provided.

Patient Name____**Date of Birth**______________________

Signature____ **Date**_____________________________

Parent/Guardian Name ____________________________________ (if applicable)

Relationship:______________________ (if applicable)

Updated 01/20/2025