850 Siskiyou Blvd., STE 6
Ashland, OR 97520

Jeff State Physical Therapy

In order to serve you I will need the following information

Patient Information:

Name: ______________________________________

Date of Birth : _______________________________ SSN:_____-_____-_____ ☐ Male ☐ Female

Address: __________________________________ City:__________________ State: _______ Zip:____________

Home Phone: (____)______________ Cell Phone: (____)______________

Person to contact in case of Emergency: _______________________Emergency Phone: (____)___________

Responsible Party if other than the patient:

Name of person responsible for this account:________________________

Relationship to Patient_________

Date of Birth : _______________________________ SSN:_____-_____-_____ ☐ Male ☐ Female

Address if different from above: _______________ City:__________________ State: ___ Zip:__________

Employer: __________________________________ Work Phone: (____)______________________________

Insurance Information: (Please make sure that we have current copies of your insurance cards)

Primary Insurance - Name of Insured (if other than person above): ______________________

Relationship to Patient_______________

Company: ____________________________ Policy # ___________________ Group#_________________

Secondary Insurance - Name of Insured (if other than person above): ______________________

Relationship to Patient____________

Company: ____________________________ Policy # ___________________ Group#_________________

Authorization and Release:

I authorize release of information if needed, and as necessary to process insurance claims, insurance applications, and prescriptions. I hereby assign to Jeffrey N Garbi PT all payment to which I am entitled for expenses related to services performed, and direct payment for such services to be made to Jeffrey Garbi PT.

Payment is required for all services at the time they are rendered (unless you have medical insurance which will be billed on your behalf). All Copayment is due at the time of service. There will be a $50 fee for any NSF checks. In the event that your unpaid account must be turned to a collection agency you may be responsible for fees incurred. Your signature below signifies your understanding and willingness to comply with this policy

Patient/Responsible Party Signature : ______________________________ Date: ______________