

**GATEWAY
SPORTS MEDICINE &
REHABILITATION PC**
10915 SE STARK ST.
PORTLAND, OR 97216
503-261-1120
FAX 503-261-8936



**MILWAUKIE
INJURY REHABILITATION &
WELLNESS CENTER**
6902 SE LAKE RD, STE 203
MILWAUKIE, OR 97267
503-607-2226
FAX 503-659-2276

Patient Information

Name		Date of Injury	
Address		Date of Birth	
Apartment		Social Security #	
City	State	Zip	
Email (optional)			
Phone Home		Phone Work	
Phone Cell		Employer	
Whom may we thank for referring you?			
Physician		Phone	

Insurance Company Information

Insurance Company Name			
Address			
City		State	Zip
Workers' Comp or Auto Accident		Health Insurance	
Claim Number		Subscriber Name	
Adjuster		ID Number	
Phone Number		Group Number	
Attorney			
Phone			

Authorizations and Consent

I hereby request medical services by Gateway Sports Medicine & Rehabilitation and/ or Milwaukie Injury Rehabilitation & Wellness Center (GSMR/MIRWC). I understand that there may be risks involved with and alternatives to medical treatments proposed by GSMR/MIRWC staff I understand that I always have the right to ask detailed questions about all aspects of my treatment. I consent to services provided and rendered by the staff of GSMR/MIRWC.

I have requested, as a courtesy to me, that my insurance company be billed for any/ all services rendered to me at GSMR/MIRWC. However, I understand that I am personally responsible for payment of all bills for services, except for an accepted Worker's Compensation claim. I understand that any returned checks will be subject to a twenty five dollar (\$25) fee and any returned check fees. I understand that in the event I fail to make any payment within the time period provided in the billing statement, I will be responsible for all costs of collections, including an award of legal fees incurred at retrial and on appeal. I have reviewed the above information and find it correct.

I authorize release of information in my medical records and history to the staff of GSMR/MIRWC. I authorize release of information in my medical records and history to my insurance company when required by the insurance company to pay any medical bills incurred by me at GSMR/MIRWC. I authorize release of medical history, both verbally and in writing, to my physician when GSMR/MIRWC staff are working under referral.

Patient, Parent or Guardian Signature

Date