Paperless Billing

Request for Electronic Access and Authorization for Email Communication

Name: _____ DOB:_____ Email: _____

I authorize Associates in Physical Therapy, PLLC to contact me using the email address provided above (including my NAME, information regarding my ACCOUNT BALANCE and instructions for accessing the PATIENT PORTAL).

I understand that:

- The information is being sent for the purpose of communicating with me and allowing me to set up an account to access the patient portal.
- My name, provider name and account balance could be viewed by anyone who has access to my email and that if my email is unsecured, the information could potentially be intercepted. (However, information in the patient portal will only be accessible to someone who has the answer to certain questions that are expected to be known only to me.), and
- The authorization will be in force and effect until I terminate my relationship with the practice or revoke the authorization by making a request in writing to:

  Associates in Physical Therapy, PLLC
  230 Grant Rd. Ste B27
  E. Wenatchee, WA 98802
  Attn: Privacy Officer

I further understand that:

- A revocation is effective only to the extent that the practice has not already relied upon it,
- Information used or disclosed pursuant to this authorization (name, email, practice name, account balance) may be used by a recipient of the email communication and then will be no longer protected by federal or state law,
- I can refuse to sign this authorization and the practice will not condition my treatment on whether I sign, and
- I have the right to inspect or copy my protected health information as permitted by federal and state laws.

Name_____ Date:_____