PHYSICAL THERAPY Cascade

PATIENT INFORMATION

Patient Information:

Patient's Name_____ Age_____ Birth Date____/____/____

Male ☐ Female ☐ Minor ☐ S.S.#_____/___/_____ Driver's License#_____

Address_____ City_____ State____ Zip_____

Home Phone_____ Other Phone(cell/work)_____Email:_____

Referring Physician_____ Primary Physician_____

How did you hear about us?_____

Marital Status:

Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐

Employment Information:

Employer_____Occupation_____

Employer's Address_____Phone#_____

Insurance Information:

Do You Have Private Insurance? ☐ Yes ☐ No

Primary Insurance Company_____ Policy# _____

Address_____ Name of Insured_____

Secondary Insurance Company_____ Policy#_____

Address _____Name of Insured_____

Responsible Party:

☐ Patient ☐ Spouse ☐ Mother ☐ Father ☐ Other (Explain) _____

(Please complete if other than patient):

Name_____S.S.#_____Age_____Birth Date____/____/____

Employed By_____ Phone#_____

Employer's Address_____ Occupation_____

Mail Statement To_____Address_____

Emergency Contact: Name_____Phone#_____Relationship to patient_____

The above information is correct to the best of my knowledge. I agree that any monies received from my insurance company over and above my indebtedness will be refunded when my bill is paid in full. I understand that I am financially responsible for all charges not covered by insurance. I will be responsible to the physical therapist for payment of the entire bill. I also understand that I am financially responsible for all cost of collection, including reasonable attorney's fees and court cost. WITH MY SIGNATURE I also give my consent to CASCADE PHYSICAL THERAPY to administer the physical therapy outlined by my physician, and hereby authorize payment from my insurance companies directly to CASCADE PHYSICAL THERAPY. A monthly bookkeeping charge will be added to accounts reflecting a 30-day-old-balance.

Patient or Guardian Signature_____ Date_____