

CLINIC NAME: CASCADE PHYSICAL THERAPY

RX DATE _____ SCHD APPT _____ TX START DATE _____ THERAPIST _____

NAME _____ SOCIAL SECURITY # _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE () _____ MOBILE () _____ WORK PHONE () _____ Ext _____

DATE OF BIRTH _____ MARITAL STATUS _____ PATIENT SEX: _____

PERSON TO CONTACT IN CASE OF EMERGENCY _____

RELATIONSHIP _____ PHONE _____

REFERRING PHYSICIAN _____ PHONE _____

DATE OF INJURY OR SURGERY _____ DIAGNOSIS _____ ICD # _____

CAUSE OF COMPLAINT DUE TO: AUTO WORK OTHER _____

NAME OF INSURED/ POLICY HOLDER

NAME _____ RELATIONSHIP TO PATIENT _____ SOCIAL SECURITY # _____

EMPLOYER NAME _____ PHONE _____

INSURANCE INFORMATION

Do you have a secondary insurance? Yes No

PRIMARY

NAME OF INSURANCE COMPANY _____

BILLING ADDRESS: _____

PHONE () _____ - _____ REPRESENTATIVE _____

POLICY/ ID# _____ GROUP# _____ EFFECTIVE DATE: _____

BENEFITS _____% DEDUCTIBLE _____ MET _____ COPAY \$ _____ OUT OF POCKET MAX _____

REQUIRES PRE -AUTH: YES NO AUTH# _____ # OF VISITS AUTHORIZED _____

AUTHORIZED BY _____ DATE _____ PLAN LIMITATIONS: _____

SECONDARY

NAME OF INSURANCE COMPANY _____ PHONE # _____

INSURANCE BILLING ADDRESS: _____

POLICY HOLDER: _____ RELATIONSHIP TO PATIENT _____

SOCIAL SECURITY/ MEMBER ID# _____ GROUP# _____

WORKERS' COMPENSATION / AUTO INFORMATION

NAME OF INSURANCE COMPANY _____ PHONE # _____

ADDRESS TO SUBMIT CLAIMS _____

ADJUSTER _____ PHONE# _____ FAX# _____

DATE OF INJURY _____ CLAIM# _____ PREVIOUS PT/OT (This Injury) YES NO

EMPLOYER _____ PHONE# _____

AUTO PATIENTS ONLY: POLICY HOLDER: _____ RELATIONSHIP: _____

AUTO POLICY # _____ MED-PAY ON POLICY: YES NO AMOUNT \$ _____

MEDICARE PATIENTS ONLY

DO YOU HAVE MEDICARE PART A & PART B? YES NO

HAVE YOU RECEIVED HOME HEALTH WITHIN THE LAST 2 MONTHS? YES NO

ARE YOU CURRENTLY RECEIVING ANY TYPE OF THERAPY AT ANOTHER FACILITY OR HOSPITAL? YES NO

HAVE YOU PREVIOUSLY RECEIVED PT/OT FOR THIS DIAGNOSIS? YES NO

Insurance Benefits and Payment Policy: The information listed above is a description of your healthcare benefits, which was given to us by a representative of your health insurance company. It is not a guarantee or authorization of payment. Actual benefits cannot be determined until the claim has been received and processed by your insurance. We will call to verify your insurance coverage. Deductibles and co-payments are due at the time of service.

I hereby give lifetime authorization for payment or insurance benefits to be made directly to this healthcare provider for services rendered. I understand that I am financially responsible for all charges not paid by my insurance company. In the event of default, I agree to pay all costs of collection and reasonable attorneys fees. I further agree that a photocopy of this agreement is as valid as the original. I further authorize that my signature on this form constitutes assignment of benefits to the above name healthcare provider.

I consent to have this healthcare provider and/or its' affiliates provide the treatment and care prescribed by my physician(s). I understand this consent may be revoked by me at any time.

PATIENT'S SIGNATURE

DATE



Insurance Verification and Billing

The support staff of Cascade Rehabilitation Associates will bill your insurance company once you have provided us with a completed intake sheet and copy of your insurance card. Verification of eligibility and benefits for physical therapy is provided as a *courtesy* to you. However, you are ultimately responsible for prompt and full payment for all services provided.

Office co-payments and/or contributions towards annual deductibles are due at the time of service. Contributions to annual deductibles are partial payments only. You may receive a bill for the remaining balance.

Cash Pay Accounts

Payment is due at the time of service.

Patient Attendance Contract

Here at Cascade Rehabilitation Associates, our patients are number one. We value your time and take pride in the fact that we try to schedule appointments that are most convenient for our patients. Cascade takes steps to ensure that you are treated quickly and efficiently when you arrive for your appointment.

In return, we ask the same consideration for our time and schedules. In order to keep everyone’s schedule running smoothly, ***it is extremely important that you arrive on time for your appointment.*** Being late may result in your appointment being rescheduled due to lack of time for a productive treatment.

Therefore, we request that you provide 8 hour notice for cancellations. Cancellations with less than 8 hour notice and “No-Shows” may be subject to a \$25 cancellation fee, due at the next visit. Please be aware that medical insurance companies do not cover any cancellation fees. Thus, ultimate payment is the responsibility of the patient.

I have read the above policies and procedures and understand my responsibilities.

Patient Signature _____ Date _____

Guardian Signature (if patient is minor) _____ Date _____