

PATIENT REGISTRATION



1360 Sunset Ave
Ferndale, WA 98248
ph: 800.848.7332
fax: 855.852.8341

17670 Dunbar Rd
Mt. Vernon, WA 98273
ph: 800.428.4003
fax: 360.428.7072

PATIENT INFORMATION					To be completed by the Guarantor.*		
First Name	M.I.	Last Name	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Date of Birth		
Home Phone		Work Phone		Cell Phone			
Mailing Address			City		State	Zip Code	
Email Address							
How did you hear about us? <input type="checkbox"/> Cascade P&O's website <input type="checkbox"/> Phone Book <input type="checkbox"/> Print Ad <input type="checkbox"/> Doctor/P.T. <input type="checkbox"/> Other _____							
INSURANCE INFORMATION				Be sure to attach a copy (front and back) of the Medicaid / insurance card.			
<u>Medicaid / Primary Ins.</u>			ID #		Insurance Phone		
Insured's First and Last Name			Group #		Date of Birth		
			Employer				
<u>Medicaid / Secondary Ins.</u>			ID #		Insurance Phone		
Insured's First and Last Name			Group #		Date of Birth		
			Employer				
ASSIGNMENT AND RELEASE					This form cannot be processed without a valid signature.		
I understand that I am financially responsible for payment to Cascade Prosthetics & Orthotics, Inc. , for charges not covered by my insurance company. I authorize medical benefits to be paid directly to Cascade Prosthetics & Orthotics, Inc. I also authorize the therapist or insurance company to release any information required for this claim. CO-PAYS ARE DUE AT TIME OF CASTING. DO NOT SEND ANY CO-PAY UNTIL ORDER HAS BEEN APPROVED.							
Guarantor* Signature X					Date		
Guarantor* Name (Please Print)					Guarantor* Date of Birth		
MEDICAL INFORMATION				To be completed by Practitioner or Guarantor.*			
Primary Care Physician			→ PCP Diagnosis Desc. / Code(s)				
Prescribing Physician			→ PP Diagnosis Desc. / Code(s)				
Mailing Address			City		State	Zip Code	
Physician's Medicaid #			Phone		Fax		
PRACTITIONER USE ONLY							
Practitioner / Person Casting			Phone		Fax		
Mailing Address			City		State	Zip Code	
Email							
Brace Style _____ STANDARD		<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both		<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both		<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both	
<input type="checkbox"/> Rx attached		<input type="checkbox"/> Letter of medical necessity attached			<input type="checkbox"/> Copy of Medicaid / insurance card attached		

*Guarantor—the person who is financially responsible for amounts not covered by insurance.