CASCADE SUMMIT PHYSICAL THERAPY PATIENT INFORMATION FORM

☐ 3901 Creekside Loop, Ste 102
Yakima, WA 98902

☐ 220 W. 1st Ave
Toppenish, WA 98948

PLEASE PRINT AND COMPLETE ALL ENTRIES					
PATIENT NAME: Last First Middle			Date of Birth	Marital Status ☐ ☐ S M	Age
Address Street City State Zip					
Home Phone	Cell Phone	Social Security No.			
Parent/Guardian Name: Last First Middle			Parent/Guardian Social Security #	Parent/Guardian Date of Birth:	
Name of Employer	Occupation	Work Phone		Extension	
Employer Address– (Street – City – State –Zip)					
Spouse's Name	Name of Employer	Work Phone			
In case of Emergency Contact:	Telephone #	Relationship			
Referring Physician	Diagnosis	Primary Physician			

INSURANCE INFORMATION					
Primary Insurance	I.D. No.	Group No.	Phone No.	Address	
Name of Insured	Group Employer	Relationship	Claim No.	Date of Injury	
Secondary Insurance	I.D. No.	Group No.	Phone No.	Address	
Name of Insured	Group Employer	Relationship	Claim No.	Date of Injury	
Attorney	Address (Street – City – State – Zip)			Phone No	

I authorize you to disclose to the above-described insurance companies any medical or other information necessary to obtain payment for the services you provide me. This authorization shall apply to all future services provided to me, and shall not expire. I assign Cascade Summit Physical Therapy all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

_____ _____

Signature Date

See reverse side of form→

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Credit Policy

As a courtesy, we will gladly bill your insurance company for you. However, you are responsible for the total balance due. Any disputed claims are between you and your insurance company. We will be happy to provide your insurance company with any information that is needed to process your claim.

Any co-payments are expected at the time of service unless previous arrangements have been made. Regular monthly payments are expected on the patient responsibility portion of your balance. For those patients with large outstanding balances a payment plan may be approved by our Business Manager-Yolanda.

I have read the Credit Policy for Cascade Summit Physical Therapy and accept its terms:

Signature_____ Date_____

Parent or Guardian Signature if under 18_____

No Show Policy

If you fail to attend physical therapy for a period of 1 week or longer without prior discussion of your absence with your physical therapist or if you fail to attend 2 scheduled appointments you will automatically be discharged from PT. If you are discharged from PT due to non-compliance you will be required to return to your physician to obtain a new Rx to continue PT. To avoid discharge, please inform your therapist of any short-term absence or notify us by phone to cancel and reschedule your appointments**. WE REQUIRE 24 HOURS NOTICE FOR CANCELLATIONS.**

Cash-Pay Policy

All patients paying in cash at time of service are entitled to a discount of 20% based on the costs we avoid by not having to prepare and send bills. All patients paying with credit or debit cards at the time of service are entitled to a discount of 15%. Payment in full after discount is due at the time of service.

I have read the No Show and Cash-Pay Policies for Cascade Summit Physical Therapy and accept their terms:

Signature_____ Date_____

Parent or Guardian Signature if under 18_____