PATIENT REGISTRATION

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

17671 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 ☐ Female ☐	Date of Birth
Home Phone		Work Phone	Cell Phone	
Mailing Address	City		State	Zip Code
Email Address			Text messages	Yes ☐ No ☐

EMERGENCY CONTACT

Name	Phone

INSURANCE INFORMATION

Be sure to attach a copy (front and back) of the Medicaid / insurance card.

<u>Medicaid / Primary Ins.</u>	<u>ID #</u>	Insurance Phone
	Group #	
Insured's First and Last Name	Employer	Date of Birth
<u>Medicaid / Primary Ins.</u>	<u>ID #</u>	Insurance Phone
	Group #	
Insured's First and Last Name	Employer	Date of Birth

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.*

Prescribing Physician	Diagnosis Desc. / Code(s)		
Mailing Address	City	State	Zip Code
Phone	Fax		

PRACTITIONER USE ONLY

Practitioner / Person Casting	Phone	Fax	
Mailing Address	City	State	Zip Code
Email			

Brace Style	____ **STANDARD** ☐ Left ☐ Right ☐ Both	____ Softy™ ☐ Left ☐ Right ☐ Both	____ FAST FIT™ ☐ Left ☐ Right ☐ Both

☐ Rx attached	☐ Letter of medical necessity attached	☐ Copy of Medicaid / Insurance card attached

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