PATIENT REGISTRATION

1360 Sunset Ave
Ferndale, WA 98248
ph: 360.384.1858
fax: 855.852.8341

17671 Dunbar Rd
Mt. Vernon, WA 98273
ph: 360.428.4003
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		Cell Phone	Text messages	Yes ☐ No ☐	
Mailing Address	City		State	Zip Code	
Email Address			Height	Weight	

EMERGENCY CONTACT

Name	Relationship	Phone

INSURANCE INFORMATION

Primary Ins.	ID #	Insurance Phone
Secondary Ins.	ID #	Insurance Phone

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.

Guarantor* Signature **X**	Date
Guarantor* Name (Please Print)	Guarantor* Date of Birth

MEDICAL INFORMATION

To be completed by Practitioner or Guarantor.*

Prescribing Physician			
Mailing Address	City	State	Zip Code
Phone	Fax		

Physical Therapist	Phone	Email Address

MEDIA RELEASE OF HEALTH INFORMATION — *Optional*

To be completed by the Guarantor.*

I hereby give my permission and authorize Cascade Dafo, Inc. / Cascade Prosthetics & Orthotics, Inc. (CASCADE) to use and disclose **photographs**, **video recordings**, and/or **audio recordings** of me, without compensation, for the following uses:

- Video (for educating practitioners on proper use of CASCADE products);
- CASCADE conference exhibits;
- Inclusion on CASCADE & CASCADE Customer websites;
- CASCADE advertisements and other print marketing materials or articles;
- CASCADE workshops (for practitioners);
- Video (for marketing purposes).

Patient - Please strike through the disclosures described above that you are not authorizing, if any.

- I understand that this authorization will not expire, but that I may revoke it at any time by notifying CASCADE in writing. If I revoke this authorization, I understand that the revocation will not apply to CASCADE's uses or disclosures that occurred prior to CASCADE receiving the written revocation request.
- I understand that once the above information is disclosed, it may no longer be protected by state and federal privacy laws and it may be re-disclosed by the recipient of the information.
- I understand that this authorization is completely voluntary and CASCADE will not withhold any treatment, goods, or services if I choose not to sign this form.

Patient/Legal Representative **X**	Date

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