CASCADE
SPORT AND SPINE

FINANCIAL POLICY AND INSURANCE INFORMATION

I understand and agree that insurance claim forms will be submitted to my insurance company as a matter of convenience only, and that I am responsible for all charges regardless of my existing medical coverage. If I do not provide insurance information or inaccurate information, Cascade Sport and Spine Rehabilitation, Inc (hereby known as "Cascade") will bill me directly for incurred charges, as well as for charges not covered by my insurance plan. If I receive a notice from my insurance company that payment is delayed or denied because additional information is required, I will contact my insurance company so that claims may be reprocessed and paid.

I hereby give authorization for payment of insurance benefits made directly to Cascade for services rendered. In the event that my insurance company forwards payment directly to me, instead of Cascade, I will immediately deliver said payment to Cascade.

I understand and agree that I am wholly responsible and liable for payment of all charges assessed for professional services rendered and will pay any sum due upon demand. I understand and agree that if it becomes necessary to commence legal actions for the collection of outstanding charges on my account, I will be responsible for any costs and/or court fees, in addition to the outstanding balance.

Signature of Person Responsible for Charges:_____ Date:_____
(PARENT OR GUARDIAN MUST SIGN FOR PATIENTS UNDER 18 YEARS OF AGE)

Relationship to Patient: ☐ Self ☐ Mother ☐ Father ☐ Legal Guardian

PRIMARY INSURANCE

Name of Subscriber:_____ Date of Birth____/____/_____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Address of Subscriber:_____
(If Different Than Patient) Street Address City State Zip

Home Phone: (_____) _____ - _____ Cell Phone: (_____) _____-_____ SS#:_____-____-_____
(If Different Than Patient)

Insurance Co:_____ Phone: (_____) _____ - _____

Subscriber #:_____ Group #:_____

SECONDARY INSURANCE

Name of Subscriber:_____ Date of Birth____/____/_____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Address of Subscriber:_____
(If Different Than Patient) Street Address City State Zip

Home Phone: (_____) _____ - _____ Cell Phone: (_____) _____-_____ SS#:_____-____-_____
(If Different Than Patient)

Insurance Co:_____ Phone: (_____) _____ - _____

Subscriber #:_____ Group #:_____