CASCADE SPORT AND SPINE

Today's Date:_____

PATIENT INFORMATION

Name:_____ SS#:_____-_____-_____
First MI Last **(REQUIRED FOR WORKCOMP & VA ONLY)**

☐ Male ☐ Female Date of Birth____/____/_____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Address:_____
Street Address City State Zip

Email Address:_____ Fax: (_____) _____-_____

Would you like to receive appointment reminders by email? ☐ Yes, notify me by email ☐ No, Do not email me

Home Phone: (_____) _____ - _____ ☐ Work or ☐ Cell Phone: (_____) _____ - _____

Would you like to receive appointment reminders by text? ☐ Yes, notify me by text ☐ No, Do not text me

Driver's License #:_____ State Issued:_____

Employer:_____ Occupation:_____
(REQUIRED FOR WORKER COMPENSATION CASES)

Emergency Contact:_____ Phone: (_____) _____ - _____ Relation:_____

Have you had Physical or Occupational Therapy this year for any condition? ☐Yes ☐No

PHYSICIAN INFORMATION

Referring Physician:_____ Date of Injury:_____

Office Address:_____ Phone: (_____) _____ - _____
Street Address City State Zip

APPOINTMENT POLICY

I understand that my doctor has prescribed physical therapy for me and physical therapy is an on-going process that requires regular attendance to be optimally effective. I understand that if I am late for an appointment, I may have to reschedule my appointment or may have to accept an abbreviated treatment for that day. I understand that if I cancel or no show for three (3) consecutive appointments, Cascade Sport and Spine has the right to discharge me from care for being non-complaint with my physician's orders.

I understand and agree that Cascade Sport and Spine requires 24-hour advance notice of cancellation. If I fail to give 24-hour notice of cancellation or fail to show up for an appointment, I may be subject to a $25 charge (which is not covered by insurance).

Signature: _____ Date: _____
(PARENT OR GUARDIAN MUST SIGN FOR PATIENTS UNDER 18 YEARS OF AGE)

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

CONSENT FOR TREATMENT

I, the Undersigned, do hereby agree and give my consent for Cascade Sport and Spine to furnish physical therapy care and treatment considered necessary and proper in evaluating and/or treating my physical condition. I also authorize Cascade Sport and Spine to furnish information to insurance carriers concerning this treatment and I hereby assign all payment for services rendered.

Signature:_____ Date:_____
(PARENT OR GUARDIAN MUST SIGN FOR PATIENTS UNDER 18 YEARS OF AGE)

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