Cascade Children's Therapy

Registration Form

DEMOGRAPHIC INFORMATION:

Today's Date: _____ Known Food/Drug Allergies: _____

Child's Name: _____ Date of Birth: _____ Sex _____ Age _____

Parents/Guardians: _____

Street Address: _____

City & Zip Code: _____

Phone #'s: Home: _____ Mom's work: _____ Mom's Cell: _____

(Circle best # to call for same day cancellation) Dad's work: _____ Dad's Cell: _____

Email: _____ Permission to Email records*? Yes No

*unsecure email correspondence to you and/or physician which may include medical records.

Primary Care Physician: _____ Clinic Phone #: _____

IN CASE OF AN EMERGENCY: LOCAL FRIEND OR RELATIVE (NOT AT SAME ADDRESS):

Name: _____ Relationship to Child: _____

Address: _____ Telephone No: _____

BILLING/INSURANCE INFORMATION:

Subscriber's Name: _____ Birthdate: _____

Insurance Co. Name: _____ Employer: _____

ID#: _____ Group #: _____

Insurance Address: _____

Customer Service telephone No.: _____

Secondary Insurance Co Name: _____

Please present your insurance card(s) to the front office for copying purposes.

____ I understand the limits of my insurance coverage. Verification of benefits is not a guarantee of coverage. **(PLEASE INITIAL)**

____ I have read & understand CCT Policies. **(PLEASE INITIAL)**

APPOINTMENT REMINDER SERVICE:

We use automated reminders to help you remember each appointment with us.

How would you like to be reminded?

( ) Phone call, my best phone number: _____

( ) Text reminders, please text to my mobile number: _____

Your Child's Medical History

On your first visit, your therapist will take a medical history from you. Answering these questions ahead of time will help her document that interview.

1. **Does your child have any allergies?** No _____ Yes _____ If yes, please specify:
   Food: Dairy _____ Tree Nuts _____ Peanuts _____ Wheat _____ Other _____
   Airborn: Trees _____ Pollen _____ Dust _____ Mold/Mildew __ Other _____
   Pets: Cats _____ Dogs _____ Other _____ **Latex** _____
   Who manages this? Primary Care Physician: _____ Allergist: _____
   Does your child take medication for this? No _____ Yes _____ Please list: _____
   Does your child always have an Epipen with him/her? No _____ Yes _____

2. **Does your child have seizures? (**Or has he/she ever had seizures?) No _____ Yes _____
   If yes, who manages this?: Primary Care Physician: _____ Neurologist: _____
   Does your child take medication for this? No _____ Yes _____ Please list: _____

3. **Does your child have any communicable diseases** (such as Tuberculosis (TB), HIV/Aids, Hepatitis, Herpes)? No _____ Yes _____

4. **Does your child have (or has he/she ever had) frequent upper respiratory infections?**
   Ear infections No _____ Yes _____
   Sinus infections No _____ Yes _____
   Strep throat No _____ Yes _____

5. **Has your child had any surgeries?** No ____ Yes _____
   If yes, please list: _____

6. **Does your child have any other health issues?**
   Sleep No _____ Yes _____
   Eating No _____ Yes _____
   Drinking No _____ Yes _____
   Reflux and or/vomiting No _____ Yes _____
   Other: _____

7. **Does your child take any other medications?** No _____ Yes _____ If yes, please list:
   _____
   _____

Client Name: _____ Today's Date:_____

CASCADE CHILDREN'S THERAPY, INC.
AUTHORIZATION FOR
MUTUAL EXCHANGE OF INFORMATION

Patient Name: _____ Date of Birth: _____

I authorize Cascade Children's Therapy and the below named agency or practitioner:

Organization/Individual: _____
Address: _____
City _____ State _____ Zip _____
Phone: _____ Fax: _____

Organization/Individual: _____
Address: _____
City _____ State _____ Zip _____
Phone: _____ Fax: _____

Organization/Individual: _____
Address: _____
City _____ State _____ Zip _____
Phone: _____ Fax: _____

Information to be exchanged:

☐ Chart Notes ☐ Clinic Notes ☐ Discharge Summaries
☐ Radiology Reports ☐ Radiology Images ☐ Operative Reports
☐ Other _____

Purpose of Exchange:

☐ Continuing Care ☐ Coordination of Care ☐ Transfer to Another Provider
☐ Other _____

Signature Required for Release/Exchange of Information:

I understand that authorizing the disclosure of this health information is voluntary. I do not need to sign this form in order to assure treatment or payment.

I understand that I can cancel this authorization at any time in writing. I understand that once the information has been released according to the terms of this authorization, the information can not be recalled.

I understand that any disclosure of information carries with it the potential for further release or distribution by the recipient that may not be protected by confidentiality laws.

This authorization will expire one year from the date signed below unless another date is entered here _____ .

_____ _____
Signature of Patient/Legal Representative Printed Name

_____ _____
Relationship to Patient Date

CASCADE CHILDREN'S THERAPY

Financial Policy

Welcome to Cascade Children's Therapy. We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your responsibility.

- All clients must complete our "Registration Forms" before seeing a therapist.
- Co-payments are due at the time of service.
- We accept cash, checks, and VISA/Mastercard.

REGARDING INSURANCE:

Insurance is a contract between you and your insurance company. In most cases, we are NOT a party to this contract. We inquire about your benefits as a service to you and are not responsible if the actual payment is different than the benefits originally quoted. We will not become involved in disputes between you and your insurance company regarding plan benefits, deductibles, co-payments, co-insurances, covered charges, coordination of benefits, "usual and customary" charges, etc., other than to supply factual information as necessary. You are responsible for the timely payments of claims submitted to your insurance company.

We are contracted providers for many insurance companies in the area and submit claims on your behalf. After we have received payment from your insurance company we will bill you for any remaining balances. You have 15 days to pay the balance upon receiving your bill. Payments not received by the due date will be charged a $20.00 late fee. Additionally, any unpaid balances over 60 days will be charged interest of 1 1/2% (18% annually). If no arrangement for payment has been made on balances unpaid after 90 days, they will be turned over to a collection agency.

Assignment and Release: I understand that I am financially responsible for payment to Cascade Children's Therapy, Inc. for charges not covered by my insurance company (except for contractual discounts). I also authorize Cascade Children's Therapy to release any information to my insurance company that is required for processing of this claim. I hereby authorize the therapy as prescribed by my physician.

_____ _____

Signature of Parent or Guardian Date

_____ _____

Witness Date