NEW PATIENT REGISTRATION

Medical Center COUNSELING AT PRO SPORTS CLUB

Clinic Use Only
Counselor: _____
ICD 10Dx: _____
Account #: _____

PATIENT INFORMATION

Today's Date: _____

Name: *(First)* _____ *(Middle Initial)* __ *(Last)* _____

Preferred Name: _____ Address: _____

City: _____ State: ___ Zip Code: _____

Gender: ☐ Male ☐ Female Age: __ Birth Date: ___/___/_____

☐ PRO Sports Club Member-Membership #_____ ☐ 20/20 LifeStyles client ☐ Non-Member

Phone: *(check best contact phone)*

☐ *Home* (___) _____ ☐ *Cell* (___) _____ ☐ *Work* (___) _____

E-mail: _____

Referring Physician: _____

Appointment Reminder:

☐ Email _____

Employment status: ☐ Employed ☐ Full-time Student ☐ Part-time Student

Marital Status: ☐ Married ☐ Single ☐ Other

EMERGENCY CONTACT

In case of an emergency, please contact:

Name: _____ Relationship: _____

Phone: *Home* (___)_____ *Cell* (___) _____ *Work* (___)_____

INSURANCE INFORMATION

Insurance Type: ☐ Medical Insurance ☐ Workers Comp ☐ Auto Insurance ☐ Cash Pay

Insurance Company: _____ ID#: _____ Group#: _____

Subscriber Name: _____ Relationship to Subscriber: _____

Subscriber Date of Birth: _____

Secondary Insurance? ☐ Yes ☐ No Insurance Company: _____

ID #: _____ Group #: _____

Subscriber Name: _____ Relationship to Subscriber: _____

Subscriber Date of Birth: _____

Party Responsible for Bill if NOT Patient: _____

Mailing Address: City: _____ State: _____ Zip Code: ___-__

Phone (___) _____ Relationship to Patient: ☐ Spouse ☐ Child ☐ Dependent

PRO SPORTS CLUB
4455 148th Ave, NE Bellevue WA 98007
(425) 885-5566

Revised 1/22/2016

Medical Center COUNSELING AT PRO SPORTS CLUB

NEW PATIENT REGISTRATION

Continued, Page 2 of 2

TERMS AND CONDITIONS *(Please read carefully and initial)*

Insurance

a. I (or my dependent) have insurance coverage and assign directly to PRO Sports Club all insurance benefits, if any, otherwise payable to me for services rendered. I understand there may be services provided and/or recommended by my provider that my insurance company may identify as non-covered services. I am financially responsible for all charges whether or not paid for by insurance. *(Initials: ____)*

b. I hereby authorize the PRO Sports Club practitioner to release all information necessary to secure the payment of benefits and by signing below I authorize all insurance submissions. *(Initials: ____)*

c. I understand that co-payments are due at the time of service. *(Initials: ____)*

Cancellation Policy

I understand that Counseling Center has a 48-hour, two business day (Mon. through Fri.) cancellation policy and that a charge for the full session ($130.00) will be billed to me directly if I fail to provide the required 48-hour notice when cancelling an appointment. I further understand that arriving late to a scheduled appointment may result in a shortened or rescheduled appointment. *(Initials: ____)*

Protected Health Information

I agree that my provider, their staff, agents and business associates may use my health information for the purposes of payment, treatment and health care operations. For a more detailed description of uses and disclosures for these purposes, please review our Client Information Form. The terms of this Client Information Form may change. If the terms do change, you may obtain a revised form by simply contacting (425) 462-2776 and requesting a revised form. You have the right to request that we restrict our uses or disclosures of your protected health information which we are otherwise permitted to make for treatment, payment and health care operations, although we are not required to agree to these restrictions. However, if we agree to further restrictions, they are binding on us. You have the right to revoke the consent in writing, except to the extent that we have taken action in reliance on it. *(Initials: ____)*

SIGNATURES

I certify that the information provided on this form is true and correct to the best of my knowledge. I give my permission for the practitioner to administer and perform such procedures as may be deemed necessary for treatment. By initialing above and signing below, I am indicating that I understand and agree to the above terms and conditions. By signing as Parent/Guardian/Account Guarantor, I accept financial responsibility for this patient.

_____ _____/_____/_____

Patient – Age 13 or older *Month Day Year*

_____ _____/_____/_____

Parent/Guardian/Account Guarantor - If patient is under age 13 *Month Day Year*

How did you hear about us? Print Ad: __ TV: __ Website: __ Friend/Relative: __ PRO Club Staff: __
Health Care Provider: __ Other: __

[Type text]