PATIENT INTAKE

Today's Date:_____/_____/______
Month Day Year

PATIENT INFORMATION

Name: *(First)*________________________*(Middle Initial)*_*(Last)* __________________________________

Preferred Name:__________________________Address:____

Apartment/Unit/Suite #: ____________

City:__________________________________State:_ Zip Code:_______-______

Gender: ☐ Male ☐ Female Age:_______ Birth Date: _____/_____/______
Month Day Year

Current Member?

☐ PRO Sports Club ☐ 20/20 LifeStyles ☐ Non-Member

Phone: *(check best contact phone)*

☐ *Home* (_____)_____-_______ ☐ *Cell* (_____)______-________ ☐ *Work*(_____)______-_______

E-mail: ________________________

Occupation:____________________________________Employer: ___________________________________

Referring Physician: _

EMERGENCY CONTACT

In case of an emergency, please contact:

Name:____Relationship: __________________________

Phone: *Home* (____) ____-_ *Cell* (______) ______-______ *Work* (______) ______- E-mail: ____

INSURANCE INFORMATION

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

Primary 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

PATIENT INTAKE

TERMS AND CONDITIONS

Please read carefully and initial:

1. 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:______)*
2. Cancellation Policy:
   a. PRO Sports Club requests that patients to honor their appointments so that we may help those in need of our care. I understand that there is a 24-hour cancellation policy and that a charge of $80 will be billed to me directly:
      - if I miss an appointment *(Initials:_______)*
      - if I fail to provide the required 24-hour notice when cancelling an appointment. *(Initials:______)*

   b. I understand that arriving late to a scheduled appointment may result in a shortened or rescheduled appointment. *(Initials:________)*
   c. Physical Therapy and Medical Massage Only: Because quality care relies on having sufficient time to provide it, arrival 10 minutes or more past your appointment time will be considered a missed appointment. In that case, I understand that I will be billed the $80 fee and that my appointment will need to be rescheduled. *(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.

______________________________ ________/________/__________
Patient – Age 18 or older *Month Day Year*

______________________________ ________/________/__________
Parent/Guardian - If patient is under age 18 *Month Day Year*

How did you hear about us? ☐ Print Ad:__________________ ☐ TV ☐ Website
☐ Friend/Relative:__________ ☐ PRO Sports Club Staff:__________ ☐ Other: _______