PATIENT INTAKE

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

PATIENT INFORMATION

Name: *(First)* ______________________ *(Middle Initial)* ___ *(Last)* ______________________________

Preferred Name: ________________________ Address: ______________________________________

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. I understand that PRO Sports Club has a 24-hour cancellation policy and that a charge of $40 will be billed to me directly if I miss any appointment or fail to provide the required 24-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: _____)*

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: ______