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: _____

Appointment Reminder Preference: *(check best option)*

☐ *Phone* (____) ____-_____ ☐ *Text* (____) ____-_____ ☐ *Email* _____

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: _____