



PATIENT INTAKE

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

PATIENT INFORMATION:

Name: (First) _____ (Middle Initial) ____ (Last) _____

Address: _____

City: _____ State: _____ Zip Code: _____ - _____

Gender: [] Male [] Female Age: _____ Birth Date: ___/___/___

Month Day Year

Current Member? [] Yes [] No (If yes, please specify):

[] PRO Sports Club [] 20/20 LifeStyles Membership #: _____

Phone: (check best contact phone)

[] Home (____) ____ - ____ [] Cell (____) ____ - ____ [] Work (____) ____ - ____

May we contact you via e-mail? (Note: we do not share membership information with any other entity)

[] Yes [] No E-mail: _____

Occupation: _____ Employer: _____

How did you hear about us? [] Print Ad: _____ [] TV [] Website

Referred By: [] Friend/Relative: _____

[] PRO Sports Club Staff: _____

[] Other: _____

Primary Care Physician: (if different from above) _____

EMERGENCY CONTACT:

In case of an emergency, please contact:

Name: _____ Relationship: _____

Phone: Home (____) ____ - ____ Cell (____) ____ - ____ Work (____) ____ - ____

E-mail: _____

INSURANCE INFORMATION:

Primary Insurance Company: _____

ID #: _____ Group #: _____

Subscriber Name: _____ Relationship to Subscriber: _____

Secondary Insurance? [] Yes [] No Insurance Company: _____

ID #: _____ Group #: _____

Subscriber Name: _____ Relationship to Subscriber: _____

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 am financially responsible for all charges whether or not paid by insurance. I hereby authorize the PRO Sports Club practitioner to release all information necessary to secure the payment of benefits and authorize my signature below on all insurance submissions. *(Initials: _____)*
- b. 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 my initials above and signature below, 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