PATIENT REGISTRATION

Patient Name:_____ **DOB:** _____ **Age:**_____

Gender: ☐ **Male** ☐ **Female** **(Please Check)** ☐ **Married** ☐ **Single** ☐ **Widowed** ☐ **Minor (Under 18Years Old)**

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Preferred contact method for appointment reminders: ☐ **Phone** ☐ **Text** ☐ **Email**

Home Phone: _____ **Work Phone:** _____ **Cell:** _____

Email: _____ **Employer:** _____ **Occupation:**_____

Emergency Contact:_____ **Relationship:** _____ **Phone:**_____

Whom may we thank for referring you to our office? (Please list the physician and/or name of the person who referred you to Biosports)

_____ _____

Physician **Friend/Relative/Patient**

PARENT/GUARDIAN/SPOUSE INFORMATION

Responsible Party (Parent/Guardian) _____ **DOB:**_____

Employer:_____ **Occupation:** _____ **Work #:**_____ **Cell:**_____

Spouse of patient or parent/guardian _____ **DOB:**_____

Employer:_____ **Occupation:**_____ **Work #:**_____ **Cell:**_____

INSURANCE

Primary Insurance:_____ **ID#:**_____ **Grp#:**_____

Subscriber Name:_____ **DOB:**_____

Secondary Insurance:_____ **ID#:** _____ **Grp#:**_____

Subscriber Name:_____ **DOB:**_____

WORK INJURIES / MOTOR VEHICLE ACCIDENT INFO

☐ **Work Related Injury - Employer where injury occurred:**_____

☐ **Auto Injury** ☐ **Other** _____

DATE OF INJURY _____/_____/_____ **Claim Number:** _____

Insurance Company Name: (company responsible for claims) _____

Claims Manager/Adjuster:_____ **Phone:** _____

Employer where injury occurred: _____

Cancellation Policy

In an effort to serve our patients, our office requires 24 hour notice if you have to cancel an appointment. We allow two "free" no show/cancellations because we understand due to illness and emergencies that you may need to cancel without notification. On the 3rd missed appointment without 24 hour notification you may incur a $50.00 cancellation fee and/or be discharged from our care. Cancellation/no-show fees are not billed to insurance and are the complete responsibility of the patient.

I acknowledge the above information is correct and it is my responsibility to inform the office of any changes. I understand that I am fully responsible for any and all costs incurred for services rendered including costs not paid by my insurance company or financially responsible party and/or costs incurred for collection on my account.

I grant permission to contact me by phone/text/email (as selected above) for the purpose of appointment reminders. I understand my information will not be shared.

Consent for Treatment, Assignment of Benefits, & Release of Information: I hereby authorize you to evaluate & treat me (or my dependent), release necessary information to secure payment and I assign directly to Biosports Physical Therapy, INC all medical insurance benefits, if any, for services rendered.

Please read entire document and ask any questions prior to signing.

Responsible party signature_____ **Date**_____

(Patients under the age of 18 or patient's on their parent's insurance plan need the signature of a parent)