

PATIENT REGISTRATION

Patient Name: _____ DOB: _____ Age: _____

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

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

Home Phone: _____ Work Phone: _____ Cell: _____

Email: _____ Employer: _____ Occupation: _____

How would you like to be contacted for appointment reminders? Phone Text Email

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)