PATIENT REGISTRATION

Patient Name: ______________________________ **DOB:** ____________ **Age:** __________

Gender: ☐ **Male** ☐ **Female** **(Please Check)** ☐ **Married** ☐ **Single** ☐ **Widowed** ☐ **Minor** **(under 18 years 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**

Email address for paperless statement: ____

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:** ______________

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 Number:** ______________________________

CANCELLATION POLICY

In an effort to serve our patients, our office requires 24-hour notice if you must 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 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 of 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 patients on their parent’s insurance plan need the signature of a parent)