PRO MEDICAL

PATIENT INTAKE

TODAY'S DATE: _____

PATIENT INFORMATION

First Name: _____ **MI:** _____ **Last Name:** _____

Preferred Name: _____ **Age:** _____ **Date of Birth:** _____ **Gender:** ☐ Male ☐ Female

Street Address: _____ **Apt./Unit/Suite #:** _____

City: _____ **State:** _____ **Zip Code:** _____

Phone *(check best contact #)* ☐ **Home:** _____ ☐ **Work:** _____ ☐ **Cell:** _____

E-Mail: _____

Current Member? ☐ PRO Club ☐ 20/20 LifeStyles ☐ Non-Member

Occupation: _____ **Employer:** _____

Referring Physician: _____

EMERGENCY CONTACT

In case of an emergency, please contact:

Name: _____ **Relationship:** _____

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

E-Mail: _____

INSURANCE INFORMATION

Insurance Type ☐ Medical Insurance ☐ Workers Comp ☐ Auto Insurance ☐ Cash Pay

Primary Insurance: _____ **ID #:** _____ **Group #:** _____

SUBSCRIBER *Name:* _____ *Date of Birth:* _____ *Relationship:* _____

Secondary Insurance? ☐ Yes ☐ No

Secondary Insurance: _____ **ID #:** _____ **Group #:** _____

SUBSCRIBER *Name:* _____ *Date of Birth:* _____ *Relationship:* _____

BILLING INFORMATION

Party responsible for bill if NOT the patient: _____

Address: _____

Primary Phone: _____ **Relationship to Patient** ☐ Spouse ☐ Child ☐ Dependent

PRO MEDICAL

PATIENT INTAKE

PATIENT'S PRINTED NAME: _____

TERMS AND CONDITIONS

Please read carefully and initial.

INSURANCE:

- I *(or my dependent)* have insurance coverage and assign directly to PRO Medical 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: _____)*
- I hereby authorize the PRO Medical practitioner to release all information necessary to secure the payment of benefits and by signing below I authorize all insurance submissions. *(Initials: _____)*
- I understand that co-payments are due at the time of service. *(Initials: _____)*

CANCELLATION POLICY:

- PRO Medical requests that patients to honor their appointments so that we may help those in need of our care. I understand that there is a 24-hour cancellation policy and that a charge of $80 will be billed to me directly:

  - if I miss an appointment. *(Initials: _____)*

  - if I fail to provide the required 24-hour notice when cancelling an appointment. *(Initials: _____)*
- I understand that arriving late to a scheduled appointment may result in a shortened or rescheduled appointment. *(Initials: _____)*
- ***Physical Therapy and Medical Massage Only:*** Because quality care relies on having sufficient time to provide it, arrival 10-minutes or more past your appointment time will be considered a missed appointment. In that case, I understand that I will be billed the $80 fee and that my appointment will need to be rescheduled. *(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)*: _____ **Date:** _____
(Month / Day / Year)

Parent/Guardian *(If patient is under age 18)*: _____ **Date:** _____
(Month / Day / Year)

How did you hear about us?

☐ Print Ad _____ ☐ TV ☐ Website ☐ Friend/Relative _____ ☐ PRO Club Staff _____

☐ Other _____