Sandro E. Fubler, BSc (Hons) PT, MSc. CRPT

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New Client Registration Form

PATIENT'S NAME (Last, First, Middle)	PATIENT BIRTH DATE (MM/DD/YYYY)	POLICY CERTIFICATE NUMBER
PATIENT'S ADDRESS (No., Street)	PATIENT RELATIONSHIP TO INSURED SELF/ SPOUSE/ CHILD/ OTHER	INSURANCE COMPANY NAME
PARISH: POSTAL CODE:	PATIENT STATUS SINGLE/ MARRIED/ OTHER	POLICY HOLDER ADDRESS (No., Street)
TELEPHONE:	EMPLOYED/ RETIRED/ FULLTIME STUDENT/ PART TIME STUDENT	PARISH:
EMERGENCY CONTACT NAME	EMPLOYER NAME OR SCHOOL NAME	POSTAL CODE: TELEPHONE:
EMERGENCY CONTACT NUMBER	POLICY HOLDER'S NAME	GROUP POLICY NUMBER
	EMAIL	POLICY HOLDER BIRTH DATE (MM/DD/YYYY)

Consultations & Assessments

We thank you for choosing *Evolution Healing Centre*. Please be aware that all treatment plans are designed with your specific needs in mind. The success of treatment plans are subject to your individual compliance with the recommendations of the physiotherapist.

Cancellations

Evolution Healing Centre and B.P.R.A. Ltd. has a 24 hour cancelation policy. All appointments cancelled less than 24 hours in advance are charged at 50% of the cost of the appointment. Please be aware that MISSED APPOINTMENTS ARE NOT PAYABLE BY YOUR INSURER UNDER ANY CIRCUMSTANCES. Please cancel on time via email, telephone or with a telephone message. Please cancel appointments that you cannot attend as early as possible to allow us to schedule and utilize this time for other clients. We thank you in advance for your respect for our time as we remain respectful of yours.

Payment for Services

We accept cash, major credit/ debit cards or direct debit bank transfers as payment for services rendered. Payment is due within ten (10) business days of the appointment time. Most health insurers cover a significant portion of our therapeutic services.

Insurance Coverage

All Bermuda based insurers have their own schedule of payment for physiotherapy services. Please check with your own insurance company for the coverage details attached to your policy. We will bill your insurance company for their portion of the physiotherapy services rendered unless you voice a preference to carry out your own billing and pay in full for these services. Please be aware that clients must assume financial responsibility for their own co-payments and for any services rendered not covered by their insurer.

I hereby affirm that I have read, understood and agree to comply with the above statements and policies outlined by *Evolution Healing Centre* I authorize the payment of health benefits to this healthcare provider and the release of medical or other necessary information necessary to process insurance claims.

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PRINT NAME SIGNATURE OF PATIENT/ GUARDIAN