



Physical Therapy for Optimum Performance

Corpore Sano, LLC

Sports + Orthopedic Physical Therapy
 Bicycle Biometrics
 Sports Performance

PATIENT INFORMATION

Date _____	Referring Doctor _____
Last Name _____	How did you hear about us? _____
First Name _____ MI _____	Top 3 Reasons for Today's Visit
Address _____	1. _____
City _____ Zip _____	2. _____
Home Phone _____	3. _____
Cell Phone _____	
E-Mail Address _____ file in them.	
Sex: M ___ F ___ Age ___ Birth Date _____	
Marital Status: S ___ M ___ D ___ W ___	
Occupation _____	
Employer _____	
Work Phone _____	
Emergency Contact _____	
Phone _____ Relationship _____	

CERTIFICATION

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the practitioner to administer and perform such procedures as may be deemed necessary for treatment.

SIGNED: _____ DATE: _____

PATIENT FINANCIAL RESPONSIBILITY STATEMENT

I understand that I will reimburse Corpore Sano, LLC a fee of **\$50.00** if I do not arrive for my previously scheduled treatment or cancel my treatment without at 24-hour notice. I also understand that Corpore Sano LLC may contact my physician, insurance company and/or employer if I do not arrive for my scheduled treatment. Returned check fee: \$25.00 per occurrence.

SIGNED: _____ DATE: _____