Prairie Trail Physiotherapy Intake and Consent Form

Name (Print)________________________________D.O.B.:(yyyy/mm/dd)___________________

____
Address (Number, Street, Town, Province) Postal Code Phone #

____
Email **(I consent to receive appointment reminders: Yes_____ No____)**

Emergency Contact/Relationship/Phone #: ____

_______________________________ ____
WCB or MPI Claim# Case Manager/Adjudicator Name and Phone #

How did you hear about us?

- Doctor (Name) ________________________________
- Alternate Medical Professional ____________________
- Friend (Name) _________________________________
- Internet: Google ☐ YellowPages.ca ☐
- Other Advertising (Street sign, etc.) ☐

I ________________________________, consent the right to release my medical information and/or communication to the following, as listed below: ________ (Initial)

Referring or supervising Doctor: ____

Family Doctor: ____

Other: ____

<u>**PAYMENT POLICY**</u>**:** Prairie Trail Physiotherapy's payment policy is that **payments be made upon completion of each physiotherapy treatment**. If we are direct billing another agency, **your uninsured portion/co-pay must also be paid upon completion of each physiotherapy session**. **I understand I am responsible to pay all costs not covered by my insurance or third party payer.**

<u>**CANCELLATION POLICY**</u>**: Any cancellations must be made at least 24 hours in advance** to the appointment time. If this does not occur, I understand I will be required to pay the **No Show Fee ($35.00)**, according to the cancellation policy. **I agree and understand Prairie Trail Physiotherapy's payment policy and cancellation policy_______ (Initial).**

I have read and understand the:

- **"Consent for Treatment & Release of Information form" ______ (Initial)**
- **"Acupuncture Consent Form" ______ (Initial)**
- **"Dry Needling Consent Form" ______ (Initial)**
- **I agree to undergo treatment by the Physiotherapist _______ (Initial)**

__________________________ ________________ ______________________________________
Patient Signature Date Therapist Signature