Date: ___________________

PERSONAL INFORMATION:	☐ Male Female
Name:	Email:
Preferred Name:	Personal Health Number:
Date of Birth (MM/DD/YYYY):	Family Doctor:
Address:	Dr's Phone Number
City: Postal Code:	Emergency Contact:
Home Phone:	Relationship:
Cell Phone:	Contact's Phone Number:

ACCIDENT-RELATED CLAIMS

- ☐ WorkSafe
- ☐ ICBC

Claim Number: ___________________________
Date of Accident (MM/DD/YYYY): ____________

Adjuster: _______________________________
Adjuster's Phone Number: ________________

EXTENDED HEALTH

Insurance: _______________________________
Name on Card: ___________________________

ID: _____________________________________
Policy: __________________________________

PRIVACY AND SHARING OF INFORMATION

I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

Initial: _______________

CANCELLATION POLICY

Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in the therapists' day that could have been filled by another patient. As such, we require 24 hours notice for any cancellations or changes to your appointment. Patients who provide less than 24 hours notice, or miss their appointment, will be charged a cancellation fee.

Initial: _______________

RATES AND FEES

I understand that rate are subject to change, and if they do, the clinic will post the changes on the website and at the clinic with signage allowing a minimum of 30-days notice. I understand that I am fully responsible for payment of services received at Fraser Life Physio in the event that a third-party insurer (ICBC/WSBC/other) denies a claim or refuses payment in full or in part. I understand that I am responsible for and agree to pay the outstanding balance.

Initial: _____________

INFORMED CONSENT

I hereby consent to examination by my practitioner (Physiotherapy, Massage, Acupuncture and Kin) Some removal of clothing articles, palpation (manual examination) of body part (s) and close observation of body part (s). I hereby consent to treatment by my practitioner, within their scope of practice. I understand that treatment will be discussed with me prior to its application and that at anytime I have the right to refuse treatment. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge that with any treatment there can be risks and those risks have been explained to me and I understand those risks. (Assessment and treatment may result in increased soreness and pain; acupuncture can result in feeling fatigue, chills, or some bleeding.)
I understand that my practitioner might recommend other therapies for my benefit but I am free to choose the therapist here or take treatment elsewhere. At anytime a product is recommended to aide in my recovery I have the right to refuse, consult a second opinion or search for another vendor. I acknowledge that my practitioner must be fully aware of all my existing medical conditions even if I might think they are not related to therapy. I have disclosed to my practitioner all of the medical condition affecting me. It is my responsibility to update my practitioner on my medical history. If you are in doubt always inform the practitioner and let her/him evaluate the importance and need of the information provided by you. I authorize my practitioner (Physiotherapy, Massage, Acupuncture and Kin) to release or obtain information pertaining to my condition (s) and/or treatment to/from my other caregivers or third party payers. I have read the above noted consent. By signing this form, I consent to assessment and treatment that will be discussed with me by my practitioner (Physiotherapy, Massage, Acupuncture and kin). I understand that after the assessment my treatment plan will be discussed and a verbal consent as well as a signature on the assessment from will be requested by the practitioner. At any time I may withdraw my consent and treatment will be stopped. HIC- FraserLife Willowbrook Physio and Rehab is The health information custodian of all my records and reports of treatments under any practitioner at this clinic. I understand at anytime (up to 10 years) I need information on my treatment or my health records, I can gain them at FraserLife Physio and Rehab

Signature: _________________________ Date: _____________________________