

PERSONAL

*** Please read and fill in all information in detail ***

☐ All information in this section has not changed since my last visit. Please proceed to the Coverage section.

First Name: _____ Last Name: _____ Date of birth: _____
(mm/dd/yy)

Current Address: _____

City: _____ Province: _____ Postal Code: _____

Email Address _____ Home Phone _____ Alternate Phone: ☐ Cell ☐ Work

Health Card No.: _____ Gender: ☐ Male ☐ Female

Emergency Contact Person _____ Relationship _____ Phone _____

PHYSICIAN DETAILS

Family Physician (full name): _____ Phone: _____

Incident Doctor's Name & Phone: _____ ☐ Same

Referring Physicians Clinic Name: _____

COVERAGE & REFERRAL

☐ Extended Health Care ☐ MVA ☐ WCB ☐ Law Firm ☐ Self Pay ☐ PCN ☐ Other

How did you hear about us? ☐ Genesis Community Centre ☐ Google ☐ Radio/Newspaper _____

☐ Physician _____ ☐ Friends/Relatives (full name) _____ ☐ Other _____

EMPLOYER INFORMATION

Company Name: _____ Occupation/Position: _____

Employer/Manager Name: _____ Phone: _____ Fax: _____

HEALTH & GENERAL INFORMATION

1. Primary complaint (or body part injury or pain): _____

2. Past surgeries or injuries you've had: _____

3. Other concerns your Therapist/Doctor should be aware of: _____

PRENATAL CLIENTS

☐ I am not sure if I am pregnant ☐ I am not pregnant ☐ I am pregnant This is my 1st / 2nd or _____
pregnancy. I am _____ (number) week(s) into my ☒ 1st ☐ 2nd ☐ 3rd trimester.

Anything else you would like your Therapist/Doctor to know? _____

EAST HILLS PHYSIOTHERAPY & MASSAGE CLINIC

Unit 303, 409 East Hills Blvd SE, Calgary, AB T2A 4X7 P: (403) 207-1960 F: (587) 333-0082

E: INFO@EASTHILLSPHYSIO.COM www.easthillsphysio.com

CONSENT FOR ASSESSMENT & TREATMENT

Assessing Physiotherapist/Chiropractor will collect all the necessary information pertaining to your injuries for assessment purposes and explain the treatment techniques that may include Manual Therapy to Joints and Muscles, use of therapeutic electrical modalities, Acupuncture (use of needles), and exercise therapy. Your Physiotherapist/Chiropractor will also explain the benefits and side effects, if any, during the treatment period. It is **your responsibility** to inform the treating Therapist/Chiropractor if you **DO NOT** understand the assessment and treatment plan. At any time, if you choose not to continue to participate in the treatment plan, you must inform the treating therapist/Chiropractor immediately.

☐ I **UNDERSTAND** and choose to continue with assessment and treatment.

Patient/Parent/Guardian Signature*: _____ Date: _____

Representative Witness Signature: _____ Date: _____

Consent for Prenatal Physiotherapy

I, _____ (signature), authorize East Hills Physiotherapy to administer physiotherapy/chiropractor to me during my pregnancy. I understand that East Hills Physiotherapy **strongly** encourages me to communicate with my physician about the potential benefits and risks.

CONSENT FOR RELEASE OF MEDICAL RECORDS

I authorize East Hills Physiotherapy to release or request any information from Physicians, Diagnostic Centers, Insurance Companies, Employers and Law Firms with respect to my care.

Patient/Parent/Guardian Signature*: _____ Date: _____

BILLING & PAYMENT

I authorize East Hills Physiotherapy to submit claims on **my behalf** to my insurance company and I am responsible to **pay any co-payment or any outstanding balance** for my Physiotherapy, Chiropractic & Massage services at each appointment, upon arrival. In the event my insurance company denies the payment for any reason, **I would be solely responsible to pay for my Physiotherapy, Chiropractic & Massage services.**

OR

If I **do not** carry any insurance coverage, then I am **fully responsible** to pay the complete fee amount for my Physiotherapy, Chiropractic & Massage services at each appointment, upon arrival.

Patient/Parent/Guardian Signature*: _____ Date: _____

CANCELLATION POLICY

Please provide **24 HOURS** cancellation notice for all **Physiotherapy, Chiropractic & Massage** appointments. We reserve the right to charge the cancellation fee for **all cancelled or missed appointments** without **24 hours'** notice. **Please note that your insurance is not responsible for covering the cost of any cancellation fees.**

PHYSIOTHERAPY & CHIROPRACTIC CANCELLATION FEE: Per Session - \$30.00

MASSAGE CANCELLATION FEE : **30 min - \$27.50 / 45 min - \$35.00 / 60 min - \$45.00 / 90 min - \$65.00**

I have read, understood and agreed to the cancellation policy as stated above.

Patient/Parent/Guardian Signature*: _____ Date: _____

* If you are under the age of 18 years, Parent/Guardian must sign.

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