CLIENT INTAKE FORM

Please mark only the ones that apply to you: (P=Past or C=Current)

____ High/Low Blood Pressure	____ Dizziness/ Fainting	____ Joint Reconstruction
____ Stroke/Aneurysm	____ Nausea	____ Bone Fracture
____ Pace Maker	____ Spinal Injury	____ Arthritis
____ other Heart Condition	____ Head Injury	____ Osteoporosis
____ Varicose Veins	____ Epilepsy/Seizures	____ Implants
____ Circulatory conditions	____ IBS/Colitis	____ Skin Conditions
____ Kidney Disease	____ Asthma	____ Cancer
____ Urinary condition	____ Chronic Sinitus	____ Hepatitis
____ Pregnant	____ Respiratory condition	____ HIV
____ Heart Attack	____ Headaches/Migraines	____ Joint Dislocation
____ Bruise Easily	____ Neurological conditions	____ Transplants
____ Diabetes	____ Digestive condition	____ Contagious condition

Please let us know how you heard about Physio Collective? (circle one)

Physician or Health/Rehabilitation Clinic	Family or Friend
Instagram/Facebook	Walk or Drive by
Internet Search	Advertisement
Other: _____	

Name of referrer: _____

Fee Policy

Physio Collective will bill your insurance company on your behalf when we can verify that payment will be received by the clinic directly.

I understand that I am responsible to pay for my treatment(s) *at the time of service*

1. When I do not have any insurance that will cover the treatment
2. When my insurance company sends payment directly to me or requires that I pay and submit my expenses
3. When my coverage does not pay 100% or has been used up (I am responsible for the co-payment)
4. When Physio Collective's direct billing system is out of order

I understand that I am responsible for all fees incurred at Physio Collective associated with my treatment(s) and agree to pay any and all outstanding balances on my accounts.

Cancellation Policy

By making an appointment, it is my responsibility to attend, as lateness or missed appointments inconvenience everyone. A **minimum 24 hours** is required, otherwise **YOU WILL BE CHARGED A FEE** for late cancellations or missed appointments.

Signature_____ Date_____ Witness_____

CLIENT INTAKE FORM

CONFIDENTIAL PATIENT INFORMATION: In accordance with the privacy policy at our clinic, ALL client information is kept confidential. Please fill out your legal name and information as appears on your CareCard.

CLIENT INFORMATION:

First Name: _____ Last Name: _____ Middle Initial: _____

Date of Birth: (DD/MM/YYYY) Gender: _____ PHN (Care card #): _____

Address: _____ City:_____

Province: _____ Postal Code: _____ Email: _____

Primary Phone: _____ Secondary Phone: _____

Occupation: _____ Employer: _____

Physician: _____ Phone: _____

**** For out of province clients please provide your address that is listed with your PHN number, for billing through BC Health (ICBC, WSBC, MSP).*

INSURANCE INFORMATION: (circle one)

Do you have MSP Premium Assistance? YES NO

Are you seeking treatment for a claim? ICBC WSBC

Are you covered by extended health benefits? YES NO
(Example: BlueCross, Great West Life, Manulife etc.)

***If Yes, please fill out Benefit Assignment Form and Electronic Transmission Authorization and Consent Form for Direct Billing.*

MEDICAL HISTORY:

Have you received treatment for your current injury prior to attending Physio Collective? YES NO

Please indicate which treatments you have received. Please mark **P**=Past or **C**=Current.

Physiotherapy ____ Massage Therapy _____ Kinesiology _____ Chiropractic_____

Other: _____

Relevant History of Injuries/Car Accidents/Illnesses/Surgeries:

_____

_____

Current Medications: _____

Known Allergies: _____