Bentall Physiotherapy
powered by movement

Confidential Patient Information

Name: _____ _____ (used: _____)

Address: _____ City: _____ Postal Code: _____

Home Phone: _____ Work: _____ Cell: _____

Email: _____ Date of Birth: _____ Gender: ○ M / ○ F

Care Card #: _____ Occupation: _____

Family Doctor: _____ Phone: _____

How did you hear about us? _____

Briefly describe your main complaint: _____

Insurer: ○ ICBC / ○ WorkSafe Claim #: _____ Date of Injury: _____

Adjuster: _____ Phone #: _____ Fax #: _____

FOR OFFICE USE ONLY Treatment Areas: _____

Please indicate if any of the following apply to you and provide details:

○ Pacemaker _____ ○ Pregnant _____ ○ Heart Attack/Stroke _____

○ Diabetes _____ ○ Cancer _____ ○ Other _____

Payment Policy

I understand that payment for services received at Bentall Physiotherapy Clinic is my responsibility. It is also my responsibility to pursue coverage for treatment(s) with insurers. In the event that my claim is denied or the third party payer refuses to pay all or any of the full amount billed, I am responsible for paying the outstanding amount.

Cancellation Policy

We require 24 hours notice for cancellation of your appointment. If you do not attend an appointment or give a sufficient notice a cancellation fee of $30.00 will be applied.

Medical Records Release Consent

I, _____ give Bentall Physiotherapy a consent to communicate with my family doctor and any other medical professionals to obtain necessary information, records and test results to facilitate my treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

Signature: _____ Date: _____