



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: