Purcell Physiotherapy

Patient Intake Form

Date: _____

First Name:	Last Name:	
Guardian (if minor):		
D.O.B: M D Y	Age:	Gender: M / F / Other
Home Address:		
City:	Province:	Postal Code:
PHN # (MSP care card):		
Home Phone:	Cell Phone:	Work Phone:
Do you want to receive text reminders for your appts? Yes / No		
Your occupation:	Email:	
Injury:	Surgery Date (if applicable):	
Family Doctor:	Referring Doctor (if different):	
Emergency contact Information: Name:	Relationship:	Phone #:
How did you hear about us?		

Extended Health Information - Canada Life, Pacific Blue Cross, Green Shield, Sun Life, etc.

Insurance Company Name: _____

Policy #: _____ I.D/Certificate #: _____

Policy Holder Name: _____ Relation to Policy holder: _____
Policy Holder's date of birth: _____

* If unsure which numbers to write down, bring your information to the desk and we would be happy to help.

*I give consent for Purcell Physiotherapy to bill my extended health on my behalf. Initial: _____

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Government Billing

Medical Services Plan (MSP) Supplementary Benefits provide partial payment for certain medical services obtained in British Columbia. The government will contribute to a total of 10 treatments per calendar year.

- These treatments are shared between physiotherapy, massage therapy, acupuncture, naturopathy, chiropractic and non surgical podiatry.
- The government covers $23.00 of the appointment fee and the patient is responsible for the user fee. See our fee list at the front desk or ask a staff member for more information.
- Once these 10 appointments have been used up, the patient is responsible for the full treatment fee.

I give consent for Purcell Physiotherapy to check my eligibility for Supplementary Benefits.

Initial: _____

* **If eligible**, you will be asked to sign MSP's consent form in addition to this consent form.

Release of Information

I give Purcell Physiotherapy my consent to release/obtain/share information from the following individuals with respect to my care (via email/mail/fax/or phone) as well as give a verbal report of my assessment, treatment plan, interim report, discharge plan and follow up reports.

Doctor(s): _____ Phone: _____ **Initial:** _____

*If applicable:

Health professionals: _____ **Initial:** _____

Lawyer: _____ **Initial:** _____

Other: _____ **Initial:** _____

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Fee Policy

- I understand that payment for services at Purcell Physiotherapy are my responsibility and payment is due at the time services are rendered:
- Appointments missed without notice may be subject to a "no show" fee of $30.00, payable before your next appointment. If you are 10 mins or more late to your appointment you may need to reschedule and be subject to a "no show" fee.
- Outstanding payments will be subject to a 2% interest charge after 30 days.

Initial: _____

Consent for Treatment

- I grant permission to the physiotherapist to assess and provide treatment as discussed during the initial visit. I will be given a full explanation of these interventions to be used and the potential risk/benefits of them. I will tell my therapist if I have not received enough information or do not fully understand. I understand that I have the right to refuse treatment at any time.
- I understand that by entering this public building, there is a risk of being exposed to the COVID-19 virus. I agree that if I have any symptoms (fever, chills, shortness of breath, difficulty breathing or cough) I will let Purcell Physiotherapy know prior to my appointment.

Signature: _____ Date: _____
(guardian, if minor)

Witness (clinic staff): _____ Date: _____