# Purcell Physiotherapy

## ICBC 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 Dr: | |
| Emergency contact Information:<br>Name: | Relationship: | Phone #: |
| How did you hear about us? | | |

## 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.

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

*If applicable:

Other Physiotherapist: _____ **Initial:** _____

Other Health professionals: _____ **Initial:** _____

# Purcell Physiotherapy

## ICBC Patient Intake Form

### ICBC Claims

Claim #: _____ Date of Injury/Accident: _____

Claims Specialist (if assigned one): _____

Phone Number: _____ Email: _____

Injured Body parts: _____

***** I understand that Purcell Physiotherapy will be in contact with ICBC in regards to my treatment.

Initial: _____

***** 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 may be subject to the "no show" fee. Initial: _____

### Consent for Treatment

- I, the undersigned, 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: _____