**Personal \*\*\*Please Read & fill in all information in details\*\*\***

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

****All the information in this section has not changed since my last visit. Please proceed to the Referral Section below.

**First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **(Mm/dd/yy)**

**Current Address** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**City** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Province** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Postal Code:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Email Address Home Phone Alternative Phone #: Cell Work**

**Health Card No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: Male / Female**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact Person Relationship Phone**

**Physician Details:**

**Family Physician** Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Clinic Name** & Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Incident Physician** Name & Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Same**

**Coverage & Referral:**

Extended Health Care: (ex: Alberta Blue Cross or other)  MVA WCB  Law Firm  Self Pay

**How did you hear about us**: **** Sage Hill Community,  Google,  Radio \_\_\_\_\_\_\_\_\_  Physician \_\_\_\_\_\_\_\_\_

 Friends/Relatives (full name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Newspaper/Magazine \_\_\_\_\_\_\_\_\_  Other \_\_\_\_\_\_\_\_\_

**Employer Information**

Company Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nature of Your Job & Job Title (Occupation) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Employer/Manager \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **For Prenatal Clients, only - Please Fill in What Applies To You:**

I am not sure if I am pregnant  I am pregnant  This is my 1st, 2nd or \_\_\_\_\_\_\_\_ Pregnancy

 I am \_\_\_\_\_\_\_\_\_\_\_\_\_ (number) week in my \_\_\_\_\_\_\_\_\_ (1st, 2nd, 3rd) trimester

Anything else you would like your therapist to know?

**Please read the Consent for Prenatal Physiotherapy**

**\*\*\*For MVA only\*\*\*** Have you completed Accidents Benefits Package (AB1 & AB2)? Yes No

**\*\*\*For WCB only\*\*\*** Have you completed WCB Intake form Yes No

**\*\*\*For Private only\*\*\*** Have you completed Direct Electronic Submission Form Yes No

**Consent**

**Consent for Assessment and Treatment:**

Assessing Physiotherapist will collect all the necessary information pertaining to your injuries for assessment purpose. Explain the treatment techniques that may include Manual Therapy to Joints and Muscles, use of therapeutic electrical modalities, Acupuncture (use of needles) if needed, Exercise therapy. Your Physiotherapist will also explain the benefits and side effects if any during the treatment period. It is **your responsibility** to inform the treating therapist if you **DO NOT** understand assessment and treatment plan. At any time if you choose not to continue to participate in the treatment plan you must inform the treating therapist immediately.

 I **UNDERSTAND**, & choose to continue with assessment & treatment

**Patient/Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

If you are under the age of 18, Parent/Guardian must sign

Representative Witness Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent for Prenatal Physiotherapy**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (sign), I authorize *SageHill Physiotherapy & Massage Centre* to administer physiotherapy to me during my pregnancy. I understand that *SageHill Physiotherapy & Massage Centre* strongly encourages me to communicate with my physician about the potential benefits and risks.

**Medical Records Consent**

**Release of Medical Record:**

I authorize *SageHill* Physiotherapy and Massage Centre to **Release or Request** any information from **Physicians**, **Diagnostic Centers**, **Insurance Companies, Employers, and Law Firms** with respect to my care.

**Patient/Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

If you are under the age of 18, Parent/Guardian must sign

**Billing & Payment**

**Payment for Service Acknowledgement**

I authorize *SageHill* Physiotherapy and Massage Centre to submit claims on **my behalf** to my insurance company and I am responsible to **pay any co-payment or any outstanding balance** for my physiotherapy & Massage services at each time of the appointment upon arrival. In the event my insurance company denies the payment for any reason, **I would be solely responsible to pay for my physiotherapy & Massage services. OR**

If the client **does not** carry any insurance coverage, then Client is **fully responsible** to pay the complete fee amount for his/her Physiotherapy / Massage services at each time of the appointment upon arrival.

**Patient/Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

If you are under the age of 18, Parent/Guardian must sign

**Cancellation Policy**

Please provide **24 HOURS** cancellation notice for all **Physiotherapy / Massage** appointments. We reserve the right to charge the cancellation fee for all cancelled or missed appointments without **24 Hours’** notice.

**Please note that your Insurance is not responsible to cover the cost of the cancellation fees.**

**PHYSIOTHERAPY CANCELLATION FEE: Per Session** $30

**MASSAGE CANCELLATION FEE:**  **30 Minutes** --- $25 **60 Minutes** --- $40

**45 Minutes** --- $32 **90 Minutes** --- $60

**I have read, understood and agreed to the cancellation policy as stated above.**

 **Patient/Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**