KERRISDALE PHYSIOTHERAPY

PRECISIONCARE

INTAKE FORM

Date: _____

Name: *Last* _____ *First* _____ *Middle*_____

BC CareCard #: _____ **DOB:** (m/d/y) ____/____/____ **Age:** _____

Home Address: *Street*_____ **Sex: M / F**

*City*_____ *Postal Code* _____

Home Tel: _____ **Cell:** _____**Wk:** _____

Email: _____

Family Doctor: _____ **Ph:** _____

Address: _____

How did you find out about us? (Please check)

( ) Signboards/ Just passed by

( ) Flyer/ Brochure : _____

( ) Friend/ Relative : _____

( ) Doctor : _____

( ) Internet : _____

( ) Other : _____

Employer: _____**Occupation:** _____

COMPLETE THE FOLLOWING IF ICBC OR WCB RELATED:

Claim Number: _____

Date of Accident: (m/d/y) ____/____/_____

Case Manager: _____ **Ph #:** _____

Fax#: _____

Lawyer: _____ **Ph #:** _____

KERRISDALE PHYSIOTHERAPY

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CONSENT TO PHYSIOTHERAPY TREATMENT and RELEASE OF INFORMATION

Welcome to Kerrisdale Physiotherapy (PrecisionCare)! Thank you for choosing us to partner with you in your recovery to optimal physical health. Before we can start, we need your permission to examine and treat you.

I, _____ , hereby give **Kerrisdale Physiotherapy (PrecisionCare)** and all healthcare professionals working under that entity consent to treatment and will not hold these bodies responsible for the outcome of such treatment with the understanding that treating therapists and healthcare professionals will practice within their scope of practice as set forth in the Health Professions Act and within the guidelines of their respective professional governing authorities. I also understand that a typical treatment session may involve body exposure and tissue palpation for the purposes of examination and/or treatment; furthermore, a gown is always available to me, and I am not obligated to remove any article of clothing if I feel uncomfortable doing so. I am free to ask pertinent questions that relate to my condition as well as the examination process and have the right to refuse treatment at any time.

Also, it may be necessary from time to time for **Kerrisdale Physiotherapy (PrecisionCare)** to communicate with others involved your care, such as your family physician, specialists, case managers, and adjusters, and keep them updated so they can better understand what your condition is and to ultimately coordinate better care for you. For instance, often times adjusters need to know your progress in order to justify more coverage. Only relevant information will be shared and all personal information will be kept strictly confidential at all times.

I, _____ , hereby authorize **Kerrisdale Physiotherapy (PrecisionCare)** to communicate and share information, which is gathered during the course of my treatment, with 3rd parties such as family physicians, specialists, case managers and adjusters with respect to my care.

_____ _____

Patient Signature (or Legal Guardian) Signature of Witness

Date: _____

AGREEMENT TO FEES

Different therapists may have different fees due to seniority, training, and area of specialization. Specialized services require extra training, often times years of training, and may require longer appointment times. The fees for these services are understandably higher than that of a regular visit. Our front desk staff will explain the cost of your visit in advance. Should the fees change the front desk staff will update you as to what the current fees are. For patients seeking coverage from ICBC for part of your fees, or WCB for the entire fee, we must receive confirmation by the 3rd party payer (typically the adjuster on your case) that your claim has been approved before charging you the reduced rates. Until such time, private rates will apply, and you can submit those receipts to your extended health if available to you. You MUST keep your receipts if you require reimbursement from **PrecisionCare Physiotherapy** once your claim has been approved by WCB.

I, _____, understand that I am ultimately responsible for paying the fee associated with each treatment session. I agree to pay this fee that is in accordance with the most current fee schedule at the time of each visit. It is my responsibility to seek reimbursement for such fees from 3rd party payers (such as ICBC and Extended Health plans) if I choose to do so. I must keep my receipt for WCB reimbursement.

_____ _____

Patient Signature (or Legal Guardian) Signature of Witness

Date: _____

CANCELLATION POLICY

Your appointment time is reserved specifically for you. If you need to reschedule an appointment, as a courtesy to your therapist and to fellow patients who may want this time slot, 24hrs notice is required. There will be a cancellation fee otherwise. We appreciate your cooperation.

I, _____, understand that in the event that I fail to provide 24hrs advanced notice to cancel my appointment a cancellation fee will be imposed. This cancellation fee is in accordance with the most current fee schedule set for the therapist I would have seen.

_____ _____

Patient Signature (or Legal Guardian) Signature of Witness

Date: _____