

**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/yyyy)

Current Address: \_\_\_\_\_

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

Email Address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone (optional): \_\_\_\_\_

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

Emergency Contact Person	Relationship	Phone
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**Physician Details:**

**Family Physician**

Full Name: \_\_\_\_\_ Clinic Name: \_\_\_\_\_

Clinic Number \_\_\_\_\_

**Incident Physician**

Full Name: \_\_\_\_\_ Clinic Name: \_\_\_\_\_

Clinic Number \_\_\_\_\_

**Referral:**

How did you hear about us:  Brentwood Community,  Google,  Physician \_\_\_\_\_,  Newspaper/Magazine  
 Friends/Relatives(full name) \_\_\_\_\_,  Other \_\_\_\_\_

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

I may be pregnant     I am pregnant

This is my 1<sup>st</sup>, 2<sup>nd</sup> or \_\_\_\_\_ Pregnancy

I am \_\_\_\_\_ (number) week(s) in my \_\_\_\_\_ (1<sup>st</sup>, 2<sup>nd</sup>, 3<sup>rd</sup>) 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 *Crowchild Physiotherapy* to administer physiotherapy to me during my pregnancy. I understand that *Crowchild Physiotherapy* strongly encourages me to communicate with my physician about the potential benefits and risks.

**Medical Records Consent**

**Release of Medical Record:**

I authorize *Crowchild Physiotherapy* 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 *Crowchild Physiotherapy* 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

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

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



## Medical Authorization Permission

Attention: Medical Records Dept.  
Clinic/hospital/physician/law firm/employer

Date: (mm/dd/year) \_\_\_\_\_

**Patient's name:**

**AHS #:**

**Date of birth:**

**Date of Injury Occurred:**

I, \_\_\_\_\_, hereby authorize Crowchild Physiotherapy to Release and Request copies of any or all information from Physicians, Diagnostic Centers, Insurance Companies, Employers, and Law Firms with respect to my care.

**Requesting /Releasing:** Related to injury due to:  MVA  WCB  General pain/injury

Diagnostic Report:  X-Ray  Ultrasound  MRI  Other: \_\_\_\_\_

Diagnostic report date: \_\_\_\_\_ Body Part(s): \_\_\_\_\_  
(If available)

Reports:  MVA Forms  WCB  Treatment Charting Notes

**OTHER:**

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

\*\*\* This authority shall continue until withdrawn, by me, in writing. \*\*\*

Patient signature: \_\_\_\_\_

Date: \_\_\_\_\_



**DIRECT ELECTRONIC CLAIM SUBMISSION AUTHORIZATION**

**Patient Name:** \_\_\_\_\_ **Date of Birth**  
(MM/DD/YYYY): \_\_\_\_\_

Name of the **Primary** Insurance Company: \_\_\_\_\_

**Primary Policy Holder Name:** \_\_\_\_\_ **Date of Birth**  
(MM/DD/YYYY): \_\_\_\_\_

Policy ID/Claim #: \_\_\_\_\_ Group/ ID: \_\_\_\_\_

**Do you have any other/secondary Extended Health Benefit?** \_\_\_\_\_

Name of the **Secondary** Insurance Company: \_\_\_\_\_

**Secondary Policy Holder Name:** \_\_\_\_\_ **Date of Birth (MM/DD/YYYY):** \_\_\_\_\_

Policy ID/Claim #: \_\_\_\_\_ Group ID: \_\_\_\_\_

Assignment of Benefits Needed? Yes / No

Coverage Period Start: \_\_\_\_\_ End: \_\_\_\_\_

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**Physiotherapy Coverage:**

Max Limit: \$ \_\_\_\_\_ Percentage covered each visit: \_\_\_\_\_ Deductibles: \_\_\_\_\_

Does your Insurance required a Doctor's referral for Physiotherapy e-Claims? Yes/No

- If Yes, Physicians Name \_\_\_\_\_ Date of Referral \_\_\_\_\_

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**Massage Coverage:**

Max amount Limit: \$ \_\_\_\_\_ Percentage covered each visit: \_\_\_\_\_ Deductibles: \_\_\_\_\_

Does your Insurance required a Doctor's referral for Physiotherapy e-Claims? Yes/No

- If Yes, Physicians Name \_\_\_\_\_ Date of Referral \_\_\_\_\_

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**Custom Foot Orthotics:**

Max amount Limit: \$ \_\_\_\_\_ Percentage covered each Year: \_\_\_\_\_ Deductibles: \_\_\_\_\_

Doctor's referral provided for Custom foot Orthotics? Yes / No

If Yes, Physicians Name \_\_\_\_\_ Date of Referral \_\_\_\_\_

Did you apply for Custom foot orthotics earlier to your Insurance? Yes/No

- If Yes, Please provide the date of Service \_\_\_\_\_

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**CONSENT**

- **I hereby certify that Crowchild Physiotherapy has been authorized to submit claims on my behalf to my Insurance Company and the information contained in the claims is complete and accurate.**
- **I am responsible to pay the co-payment, if applicable, at the time of each appointment.**
- **I understand that I am fully responsible to make full payment, if my insurance company denies my claim.**

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_