LOCAL PHYSIOTHERAPY

PATIENT INFORMATION

Name: _____ Age_____ D.O.B. _____

Last Name *First Name* *Month / Day / Year*

Address: _____

_____ _____ _____

City *Province* *Postal Code*

Home Phone No: _____ Work/Mobile Phone No: _____

Email: _____ Manitoba Health Number _____

Family Physician: _____ Referring Physician: _____

Employer: _____ Occupation: _____

How did you hear about LOCAL Physiotherapy: _____

Type of Insurance: _____ Claim No. (WCB & MPI only) : _____

Policy Number:_____ GRP Number: _____ Certificate/ID Number:_____

Name of Policy Holder: _____ Relation: _____ DOB:_____

**Secondary insurance can be presented in the office.*

To ensure that you receive quality services, we ask that you read and agree to the following:

1. We require AT LEAST 24 HOURS notice to change or cancel your appointment. If we don't receive sufficient notice, you will be responsible for the FULL COST of the missed appointment. This notice allows us to offer your appointment to someone else and adjust your physiotherapist's schedule.
2. We ask that you arrive at least 5 MINUTES prior to your appointment time.
3. LOCAL Physiotherapy direct bills to Canada Life, Manulife, Sunlife, Blue Cross and Claim Secure, MPI and WCB. For all other coverage, we will provide you with proper documentation to submit to your insurance company.
4. Please confirm what your coverage is with your insurance company. It is your responsibility to confirm whether or not you need a medical referral in order to receive insurance coverage. You are responsible for the FULL AMOUNT of your treatment at LOCAL Physiotherapy. All invoices are payable upon receipt.

I, the undersigned, authorize LOCAL Physiotherapy to commence treatment. I understand that injuries can arise by accident from the very nature of treatments, and hereby waive all rights to any claims or actions against LOCAL Physiotherapy, arising from injury, loss or damage to me or my property. I authorize LOCAL Physiotherapy to release information pertaining to my treatment to relevant healthcare practitioners.

Note: In accordance with the Personal Health Information Act (PHIA), we endeavour to protect the privacy of our clients. Please be aware, we do not disclose patient information over the phone nor provide any information about appointments without their express consent

The client acknowledges that this contract may be signed, scanned, transmitted electronically and copied and the copies thereof shall be deemed original signatures for the purposes of this Contract and all matters related thereto, with such scanned and electronic signatures having the same legal effect as original signatures.

I have read and understand the above terms and conditions.

Signature:_____ Date:_____

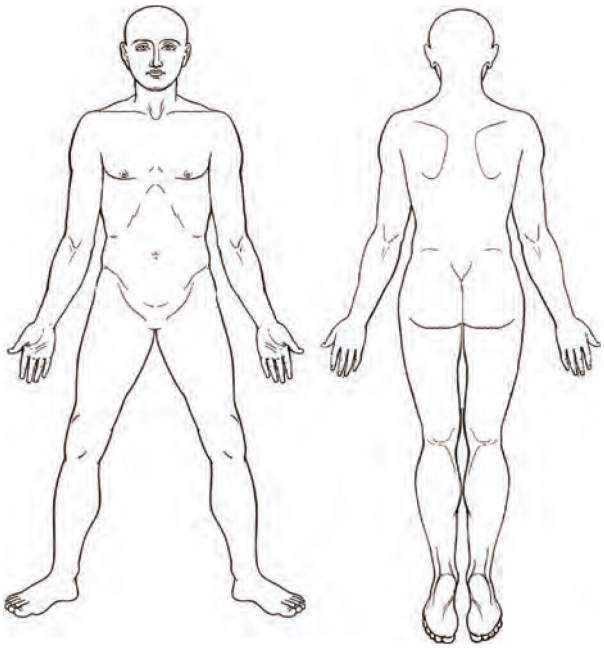
LOCAL
PHYSIOTHERAPY

PATIENT INFORMATION

Name: _____ Date of Injury or Surgery (if applicable) :_____

Health Information (check box):

- ☐ Heart Attack
- ☐ Pace Maker
- ☐ Stroke
- ☐ High/Low Blood Pressure
- ☐ Diabetes
- ☐ Pregnant
- ☐ Clotting Disorder
- ☐ Bone Disorders (Osteoporosis)
- ☐ Joint Disorders (Arthritis, Ect.)
- ☐ Other



Other Health Information _____

Major Surgeries / XRays /MRI / CT Scans / Name of Hospital / Clinic _____

Medication: _____