ALLIED PHYSIOTHERAPY HEALTH GROUP

Surrey Hwy 10 Physiotherapy & Massage Clinic

First Name _____ **Last Name** _____

Home Address_____
**Street** **City** **Prov.** **Postal Code**

Phone_____ _____ **E-mail** _____@_____
Mobile **Home**

BC Care Card No. _____ **Birth Date M/D/Y** ____/____/_____ **Family Dr.** _____

Referred by: ☐ **Website** ☐ **Friend** ☐ **Hospital** ☐ **Doctor/Clinic** _____
Doctor/Clinic Name

Please Check Off What Services You Are Interested In

☐ **Physiotherapy** ☐ **Massage Therapy** ☐ **Custom Orthotics** ☐ **Acupuncture/IMS** ☐ **Kinesiology**

Type of Visit (Please Check) ☐ **ICBC** ☐ **Work Safe BC** ☐ **MSP** ☐ **RCMP/DVA** ☐ **Extended Medical Plan**

Date of Injury: _____ **ICBC/WCB Claim Number** _____

Adjuster/Case Manager: _____ **Phone:** _____

Lawyer Name: _____ **Phone:** _____

Employer Name (WSBC Related) _____ **Phone:** _____

Do you have an extended medical plan? If yes, with who? _____

Please write your name on the line below then check the following boxes:

I, _____,

☐ **Client authorization for Disclosure of Information:**

Hereby authorize Allied Physiotherapy Health Group to obtain and/or release information regarding my treatment progress, functional abilities and return to work/activity to all the following parties listed below:

Family Doctor, Specialists, Adjusters, Employer, Lawyer, Other: _____

☐ **Consent to treatment:**

Physiotherapy treatments may include, but are not limited to the following: an assessment, manual (hands on) treatment, modalities for pain/swelling/healing, acupuncture, traction and exercise/stretching. Kinesiology sessions may include, but are not limited to an assessment and prescription or modification of exercise and stretching. I consent to the treatments offered or recommended to me by my Physiotherapist/Kinesiologist.

☐ **I consent to receive emails or texts from Allied Physiotherapy Health Group, including but not limited to appointment reminders, clinic updates and prescribed exercises.**

Appointment Confirmation Preference (Check All That Apply) ☐ **E-Mail** ☐ **Text Message** ☐ **Phone Call**

Signature: _____ **Date:** _____
Patient (or Legal Guardian)

Cancellation and No Show Policy

We understand that unplanned issues can arise and that you may need to cancel an appointment. If that happens, we respectfully ask for scheduled appointments to be cancelled at least 24 hours in advance.

When you do not come to your scheduled appointment it affects three people:

- ✓ **YOU** because you don't get the treatment you need to get better
- ✓ The **THERAPIST** who now has a empty space in his schedule since the time was reserved for you personally.
- ✓ **ANOTHER PATIENT,** who is in need of treatment, could have been scheduled for treatment if you had given us adequate notice.

There is a no show/cancellation fee of **$45 for Physiotherapy visits** and **$45 for Kinesiology visits** if we do not receive a phone call with 24 hours' notice. This charge will not be covered by insurance, it will have to be paid by you personally.

For Worker's Compensation and Motor Vehicle Injury patients, documentation of any missed appointments may be requested by your Case Manager, which could adversely affect your claim.

It is your responsibility, when you contact us to cancel your appointment, to have an **alternative time** in mind that will ensure you get the full treatment for that week. In some cases this may not be possible, but we will make every effort to accommodate your reschedule request.

Please understand that you may need to be seen by a different therapist than the one that normally treats you, if you reschedule your appointment. All of our therapists are experienced professionals, and they will review your chart, so you will be in good hands and taken care of.

Thank you for being a valued patient and for your understanding and cooperation.

This policy will enable us to better serve the needs of all patients including yourself.

Patient Signature _____ Date _____