



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

## **Welcome to the Commerce Court Health Centre**

**Physiotherapist: Scott Allen P.T., B.Sc. P.T., M.C.P.A, Registered #09264**

First Name: \_\_\_\_\_ Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date Of Birth (d/m/y): \_\_\_\_\_

Address: \_\_\_\_\_ Suite #: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_

Country: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_

Fax #: \_\_\_\_\_ Cell #: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Referred By: \_\_\_\_\_

### **Medical Information**

Did a physician refer you?  No  Yes

(If yes, please ensure that you fill out the appropriate contact information below)

If yes, was there a diagnosis? \_\_\_\_\_

Was there any related testing (i.e. x-ray, MRI, bone scan, etc.)? \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Do you have any known medical conditions? (i.e. Diabetes, High Blood Pressure etc.)

### **Physiotherapy Clinic Policies**

All information contained within your file is handled as strictly personal. Only under written consent or as required by law will this information be shared externally.

### **Appointments**

Appointment frequency and expected duration should be discussed with the physiotherapist and scheduled appropriately with the receptionist. Please check in at reception each visit. It is important that you arrive a few minutes before each treatment time, in order to prepare. If you do arrive late, you will be seen for the remainder of your scheduled time.

**Cancellations, Lateness and No-shows**

Any appointment cancelled on the same day, or no-shows, will be charged the full service fee (Which may not be covered by your extended Health Care Plan). This is necessary to ensure proper respect for treatment times and the difficulty in rescheduling with less than 24 hours notice.

**It is very important that you clarify your coverage prior to initiating physiotherapy treatment to ensure you are reimbursed to your full expectation.** Clients are responsible for full payment of their account at the end of treatment. Payment can be made by, cash, interact, or credit card. Cheques should be made payable to "Dales Health Management Inc."

**Treatment Fees**

Initial Consultation and Re-Evaluations (45min-1 hour)...\$110.00

Follow Up Visits (30 min.)...\$76.00

Missed Appointment Fee...\$76.00

\*It is the responsibility of the patient to verify the extent of insurance coverage per visit.

**Personal Belongings**

The clinic cannot be held responsible for loss of damage to personal belongings. The clinic washroom or treatment space can be utilized for changing. Bring your belongings into the treatment room with you in order to avoid the risk of loss.

**Cardiac Pacemaker, Medical Conditions**

Clients with Cardiac pacemakers, or other medical conditions should notify their therapist prior to the initial assessment.

I fully understand and agree to abide by the above policies as outlined.

Name: \_\_\_\_\_

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

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

- \*This file will contain only the record of your physical Therapy Assessments and Treatments
- \*Should you require a copy of your file, a list of commonly used abbreviations can be provided
- \*Health Information Custodian (HIC) of this File is: Scott Allen P.T.
- \*Your date of birth (day/month/year) will be utilized as your patient I.D. number