



Date: _____

Welcome to the Commerce Court Health Centre

Physiotherapist: Angela Growse, BSc, BEd, MSc(PT) FCAMPT, Registered #11966

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: Angela Growse P.T.

*Your date of birth (day/month/year) will be utilized as your patient I.D. number