FUSIONPHYSIO | **Client Information Form**

LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
ADDRESS:	City / Province:	Postal Code:
EMAIL:		

Date of Birth		**Occupation**	
BC Care Card #		**Employer**	
Sex	Male ☐ Female ☐	**Family Doctor**	
Home Phone #		**Referred By**	
Work #		**WCB Claim #**	
Emergency #		**ICBC Claim #**	
Emergency Name		**Date of Injury**	

Extended Health Company Information			
Primary Insurance	**Member Name/ Relationship/DOB**	**Policy / Plan Contract #**	**Member ID / Cert #**
Secondary Insurance	**Member Name/ Relationship/DOB**	**Policy / Plan Contract #**	**Member ID / Cert #**

Have you received physiotherapy, massage, chiropractic or podiatrist treatments at any other private practice clinic during the **Present Year**?

Yes ☐ / No ☐ If Yes: Where? When?

Consent:

1. I hereby agree and understand that I am responsible for payment of both the user fees and treatments, unless this is covered by B.C. Medical Services Plan or by alternate coverage (ICBC, WSBC, or Extended Healthcare Insurance).
2. I authorize that benefits payable under the Medical Services Plan for my physiotherapy care be paid directly to FusionPhysio Chilliwack.
3. I agree and understand that failure to provide 24 hours cancellation notice prior to any scheduled appointment will result in a charge of $35.00.
4. I hereby request and authorize release of the results of any tests performed at the of the Diagnostic Imaging Department(s) of Chilliwack General Hospital, Abbotsford Regional Hospital, or Fraser Canyon Hospital to FusionPhysio Chilliwack.
5. I hereby request FusionPhysio Chilliwack to have access to the results of any medical tests performed on me with regards to the condition for which I am seeking treatment.
6. I hereby authorize FusionPhysio Chilliwack to communicate regarding my progress to my Insurance Company/Doctor/Lawyer or their representative.
7. I hereby understand that FusionPhysio Chilliwack must collect various amounts of personal information in order to provide me with the best possible treatment, ensure my safety and the safety of other individuals, to comply with professional standards and regulations. I understand that my personal information will be protected as per this Clinic's Privacy Policy and the British Columbia Protection of Personal Information Act (PIPA).

Signature: _____ Date:_____

If under 19, signature of parent or legal guardian _____ Date: _____