HOME Care
Physical Therapy

# INTAKE FORM

## PERSONAL INFORMATION

**Full Name** :
***(PLEASE USE CAPITAL)***

**Date Of Birth** : ____/____/____ **Gender** : ☐ Male ☐ Female ☐ Other

**Address** : _____

**Phone Number** : _____ **E-Mail** : _____

**PHN #** : _____ **How Did You Find Me** : _____

**Allergies** : ☐ Yes ☐ No **If Yes Please Specify** : _____

**Medications** : _____

**Primary Mode Of Walking** :
☐ Independent With No Aids ☐ 4 Wheel Walker ☐ 2 Wheel Walker ☐ Cane
☐ Wheelchair ☐ Other, Please Specify : _____

**Reason For Visit** :

**Past Medical History** :

## EMERGENCY CONTACT DETAILS

**Contact Name** : _____ **Home Number** : _____

**Relationship** : _____ **Mobile Number** : _____


**More Information :**

780-919-0038
info@homecarephysicaltherapy.ca
www.homecarephysicaltherapy.ca


**THANK YOU**

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## INSURANCE INFORMATION

**Primary Insurance Provider Name** : _____

**Insurance Policy Number** : _____

**Group/Plan Number** : _____

**Policyholder Name:** : _____

## CANCELLATION POLICY

**Your adherence to the recommended number of treatments is a vital component of your progress with our services; therefore, we have certain rules that need to be followed in order to ensure the most optimum results. With the exception of serious emergencies, it is expected that you keep all your appointments.**

**If you need to re-schedule an appointment, we require 24 hours notice. In such a case, please call or email and arrange a makeup appointment. In an instance of cancellation without 24 hours notice, you will be charged a $40 fee. This fee will be automatically charged to your credit card on file. If you do not have a credit card, then this fee can be paid prior to your follow up session. If this fee is not paid, we will be unable to rebook until you do so. We do require you to have your credit card information on file (whether calling in to book, or when booking online). In instances of repeated non-compliance with your scheduled visits, we also reserve the right to discontinue care.**

**We appreciate you greatly as our client and strive to accomplish the results you desire.**

## CONSENT FOR TREATMENT AND BILLING AUTHORIZATION

**I, _____, hereby authorize and grant permission to the physiotherapist to carry out such examinations, procedures and treatments as may be necessary. I also authorize and grant permission of the sharing if information about me with all professionals including third party payer, legal counsel, any medical personnel e.g. doctor, chiropractor, massage therapist, physiotherapist, etc. who are providing services to me. I am aware of my option to discontinue treatments at any time after discussion with my physiotherapist.**

**I acknowledge that no guarantees have been made to me as a result of the services.**

**Additionally, I authorize the storage of my credit card information for billing purposes. I understand that this information will be securely stored and used only for processing payments related to my treatments and services. I can request the removal of my credit card information at any time.**

**I further authorize my physiotherapist to submit claims directly to my insurance provider for services rendered, if applicable. I understand that I remain responsible for any charges not covered by my insurance.**

**Signature** : _____ **Date** : _____

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**THANK YOU**