D'ARCY BAIN PHYSIOTHERAPY
We set the standard with care.

MASSAGE INTAKE FORM

PERSONAL INFORMATION

Name -

(Preferred Pronouns): Date of Birth (M/D/Y) - / /

Address -

City Province Postal Code

Phone #: Cell Phone - Home -

Email - May we communicate with you through: **Email** ☐ Yes ☐ No and/or **Text** ☐ Yes ☐ No

Family Doctor - MB Health Card # (9 Digit) -

Employer/Occupation -

☐ **Emergency Contact** or ☐ **Guardian (for patients under the age of 18)**

Name - Relationship - Phone # -

EXTENDED HEALTH CARE INSURANCE COVERAGE

Primary Insurance Company -

Plan Holder Name - Date of Birth (M/D/Y) - / /

Group/Plan # - Certificate/ID # -

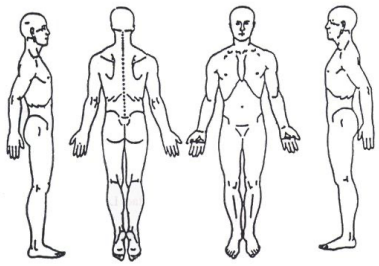
TREATMENT

Current involvement with other Health Care Professionals (i.e., physiotherapists, chiropractors, naturopath, other):

_____

Reason Treatment Requested: _____

Areas of Concern:



CONSENT

I hereby consent to treatment at D'Arcy Bain Physiotherapy at the discretion of the attending therapist. I understand that payment for services received at the clinic is my responsibility. If my treatment services are to be submitted directly to an outside agency for payment and for some reason denies or refuses to pay all or any of the full amount billed, I am responsible for paying the amount outstanding.

Signature: _____ Date: _____

CANCELLATION POLICY Our clinic requires *24-hour notice* for cancellations

*I understand that there is a fee of **$40.00** for cancelled or missed appointments if insufficient notice is given. I also acknowledge that third party funders will not pay for cancellation charges, and that I will be personally responsible for applicable fees.*

Signature: _____ Date: _____

PAYMENT REQUIRED AFTER EACH VISIT PLEASE (CASH/DEBIT/MC/VISA)