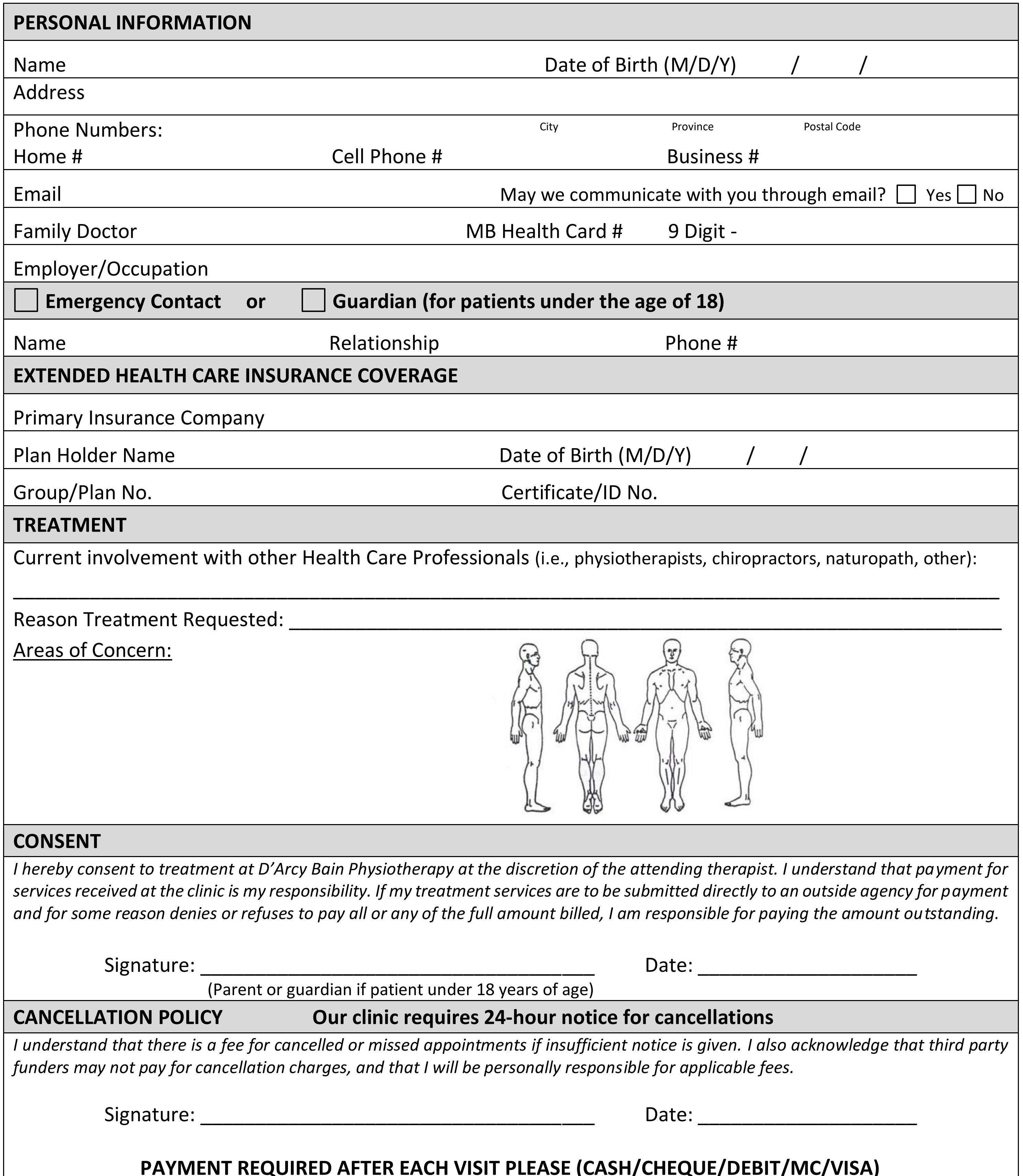
D'ARCY BAIN PHYSIOTHERAPY
We set the standard with care.
Est. 1981

MASSAGE INTAKE FORM



PERSONAL INFORMATION

Name Date of Birth (M/D/Y) / /

Address

City Province Postal Code

Phone Numbers:
Home # Cell Phone # Business #

Email May we communicate with you through email? ☐ 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 No. Certificate/ID No.

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: ______________________

(Parent or guardian if patient under 18 years of age)

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

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

Signature: ______________________________________ Date: ______________________

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