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

PATIENT 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

MB Health Card # 6 Digit - 9 Digit -

Family Doctor ☐ Referral from a Doctor (please hand to front desk)

Employer/School Occupation

Injured Area/ Area(s) of Concern

☐ X-Ray ☐ MRI/CT Scan → Date (M/D/Y) / / Location -

Current involvement with other Health Care Professionals (i.e. massage therapists, chiropractors, athletic therapists, other):

☐ 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.

Is your injury funded by: ☐ WCB ☐ MPI ☐ Are you off work as a result of the accident/injury?

Date of Accident (M/D/Y) / / Claim #

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 the third-party payer (WCB/MPI), insurance or employer, denies the claim 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 $25.00 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)