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 Numbers:
Home # Cell Phone # Business #

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 No. Certificate/ID No.

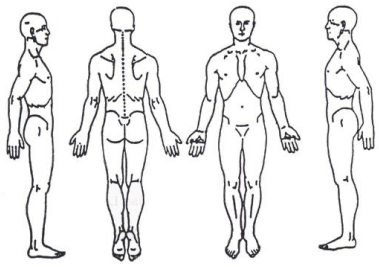
TREATMENT

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 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/CHEQUE/DEBIT/MC/VISA)