STEELCITY
PHYSIOTHERAPY & WELLNESS CENTRE

General Information

Name:_____ Date:_____

Mailing Address:_____ Postal Code:_____

Email:_____ Date of Birth:_____

Phone (H):_____(C):_____(W):_____

Employer:_____ Job Title:_____

Physician

Family Dr. Name_____ Phone #_____

Referring Dr. Name_____ Phone #_____

Billing Information

Do you have insurance? YES NO
Primary insurance:_____ Numbers:_____
Secondary insurance:_____ Numbers:_____

MPI or WCB Claim #:_____ Case Manager:_____

Acupuncture/GTT: Many of our therapists are trained in performing acupuncture. Acupuncture at some point in your course of treatment may be recommended by your therapist. There is a tray fee added for acupuncture treatments. Please check off the box that pertains to you.

I have read, understand and consent to:
Acupuncture _____ (initial)
GTT Needling _____ (initial)

Consent for Treatment and Release of Medical Information
I, the undersigned, give consent to Steelcity Physiotherapy & Wellness Centre to assess and initiate treatment by the therapist. I also authorize the release of medical information to my physician and case managers/adjustors in the case of a MPI, WCB or private insurance claim. If under 18 please have parent or guardian sign.

Attention: Service fees are the responsibility of the patient. Payment is due after each treatment unless otherwise arranged. Direct billing is available to MPI and WCB at no charge. Direct billing to other insurance providers may be able to be arranged. It is the responsibility of the patient to keep track of number of visits related to insurance coverage maximums. Failure to provide 12 hour notice of appointment cancellation will result in a $25 fee. I, the undersigned, acknowledge and understand the preceding content and agreement. Please have parent or guardian sign if under 18. _____ (initial)

_____
Patient Signature

_____ _____
Parent/ Guardian (if under 18) Please print Parent/ Guardian Please sign