Steelcity Physiotherapy & Wellness Centre

Massage Therapy General Information

Date:_____

Name:_____

Mailing Address: _____

_____

Postal Code: _____

Phone No. (H)_____ (Cell)_____

(W)_____ email_____

Date of Birth: _____ Employer_____

MD's Name: _____ MD's Phone #:_____

Referred By:

❏ Doctor ❏ Physiotherapist ❏ Chiropractor ❏ Friend/Family

❏ Self ❏ Gift Certificate ❏ Outside signage ❏ Newspaper Ad

Other (please specify) _____

Consent for Treatment/Release of Medical Information:

I, the undersigned, give consent and authorize Steelcity Physiotherapy & Wellness Centre to assess and begin treatment. I also give consent and authorize Steelcity Physiotherapy & Wellness Centre to release information only pertaining to my massage therapy to my physician identified above. I acknowledge that I am responsible for any treatment cost incurred and agree to pay after each treatment unless other arrangements have been made. Patients receiving a statement are responsible for payment within 30 days of the statement date.

Signature:_____

(Parent or Guardian if under 18)

Billing Information:

❏ Blue Cross Group # _____ Contract # _____

❏ DVA/RCMP Group (K)# _____ Authorization# _____

❏ Private Insurance Type _____ Contract # _____

Provider # _____

❏ No Insurance

Office Use Only

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