



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:

- | | | |
|--|------------------|----------------------|
| <input type="checkbox"/> Blue Cross | Group # _____ | Contract # _____ |
| <input type="checkbox"/> DVA/RCMP | Group (K)# _____ | Authorization# _____ |
| <input type="checkbox"/> Private Insurance | Type _____ | Contract # _____ |
| | Provider # _____ | |

No Insurance

Office Use Only

