Corydon Physiotherapy Clinic Nov. 2014
Physiotherapy Patient Information

First name: _____Last name: _____

Street: _____ City: _____ Postal Code: _____

Home Phone # _____ Work Phone # _____ Cell Phone # _____

E-Mail Address (very important):_____
(we will not distribute, only used for appointment reminders, your exercises, and notices)

Preferred method for appointment reminders: Email ( ) **or** Phone ( ) if so, Home or Work or Cell ph.?

Date of Birth: _____/_____/_____ Manitoba Health No:_____(for imaging results)
Month Day Year **9 Digit Personal Number**

Parent/Guardian (If under 18 yrs): _____ Family Physician:_____

Please check the box that best tells us how you decided to come here:

Friends or Family ( ) Doctor ( ) Other Healthcare Professional ( )
Yellow Pages online ( ) Yellow Pages book ( ) Our Website ( ) Online search ( )
Social media ( ) Brochure ( ) Other ( ) _____ (Please specify)

- ✓ **Cancellation Policy: Please note we run a busy clinic accommodating many patients. Not attending also generally means that it will take longer for you to recover. But if for some reason you need to move or cancel future appointments we require 12 hours notice otherwise a cancellation fee of $50 may be charged. We send out email or phone reminders the day prior to your appointment to assist you in that regard.**
- ✓ **It is our policy to receive full payment for your first appointment. This streamlines the billing process and reduces insurance company errors.**
- ✓ **Corydon Physiotherapy is pleased to provide the service of direct billing your insurer on your behalf after the first visit. We require that you complete and sign 2 insurance and authorization forms relevant to your claim and give all pertinent information regarding your claim to us. Not providing us with this information will result in all treatments being billed to you in the interim. All unused forms will be shredded.**
- ✓ **We also require that you provide us with all the information required to bill on your behalf including insurance forms, contract numbers and a Dr.'s prescription or referral (if required).**
- ✓ **Please be advised that if for any reason your insurer does not reimburse the clinic for any outstanding fees, you will be responsible for clearing your account with us.**
- ✓ **You are required to pay your account (or your portion) on a weekly basis.**

Thank you.

Signature: _____ Date: _____

Corydon Physiotherapy Clinic Nov. 2014
Payment Policies and Information

Private Insurance

Company Name: _____
Policy / Contract #: _____ Group #: _____
I.D. #: _____
% Covered by Insurance Company: _____
Maximum Per Year: _____
Referral/Prescription Required ( ) Yes ( ) No

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- ✓ **You are required to pay your outstanding account balances (or your portion) on a weekly basis.**

Thank you.

Print Name: _____

Signature: _____ Date: _____

If you have any questions regarding the above please do not hesitate to ask our front desk staff.