Cochrane Sport Physiotherapy & Massage

REGISTRATION

PLEASE PRINT

NAME: ______________________________
FIRST INITIAL LAST

ADDRESS: ______________________________

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CITY PROVINCE POSTAL CODE

EMPLOYER: ______________ **OCCUPATION:** ______________

PHONE: HOME__________ CELL __________ **AHC#:** __________

DATE OF BIRTH: __________ **AGE:** __________ **GENDER** __________
MONTH / DAY / YEAR

EMAIL ADDRESS: ______________________________
DO YOU WISH TO RECEIVE EMAIL REMINDERS FOR YOUR APPOINTMENTS? YES ☐ NO ☐

Emergency Contact Name & Number: ______________________________
Family Physician name & Clinic:
____

How have you heard of us?
☐ Our Facebook Page ☐ Our Website ☐ Newspaper Ad
☐ A friend, if so who? ______________________________
☐ A Doctor, if so who? ______________________________
☐ Other ______________________________

If in a motor vehicle accident, fill out the information below:
Name of motor vehicle insurance company: ______________________________

Adjustor: ______________________ Phone #: ______________________

Fax#: ______________________ Policy/Claim #: ______________________

PAYMENT OF SERVICES

▸**I understand that payments for services received at the clinic are my responsibility.** If my claim is to be submitted directly to an outside agency for payment, and for some reason the third-party payer, such as insurance or employer, denies the claim and/or refuses to pay all or any of the full amount billed, I am responsible for paying the amount outstanding. I understand that the fees per visit for this service are:

Fees: Assessment $ __105__ Treatment $ __80__ _________Initials

Please Continue on Back

LATE CANCELLATIONS/FAILURE TO ATTEND

▸A fee will be charged for failing to attend your appointment or canceling without 24 hours' notice. Please respect your scheduled appointment time.

_________Initials

CONSENT TO RELEASE INFORMATION

I hereby authorize this clinic to release information to my physician, insurance company and/or lawyer.

Signature: ____ Date: ____________________________
(If under 18 years of age, must be signed by a parent or guardian)

Witness: ____ Date: ____________________________

CONSENT TO PHYSICAL THERAPY TREATMENT

Physical therapy treatment techniques may include, but are not limited to: manual technique, electrotherapeutic modalities and exercise as well as other techniques such as acupuncture. A number of these may be recommended during your program. It is the policy of the Cochrane Sport Physiotherapy & Massage Clinic to ensure the benefits, side effects and potential complications of each chosen modalities explained to you by your therapist before use, as your participation in all aspects of the program is imperative to its success. Throughout your program, if you have any questions or concerns about any recommended treatment you must inform your therapist immediately so they can explain the treatment rational and/or modify your program appropriately. If at any time you chose not to participate in the program or any portion of it, you must inform your physical therapist immediately.

I understand and agree with the criteria about and as such agree to participate in an assessment and treatment program at the Cochrane Sport Physical Therapy & Massage Clinic. I understand that for the duration of my treatment, my consent may be withdrawn at any time and understand that I must inform my physical therapist.

Signature: ____ Date: ____________________________
(If under 18 years of age, must be signed by a parent or guardian)

Witness: ____ Date: ____________________________