Heather Biagi
PHYSIOTHERAPY

Intake Form

Last Name: ____________________ First Name: ____________________ Initial: ______

Date of Birth: D / M / Y Gender: M / F

MSP Care Card Number (PHN): ____________________

Address: ____

City: ____________________ Province: ____________ Postal Code: ____________

Telephone: (home) ____________________ Email: ____________________
(cell) ____________________
(work) ____________________

Referring Doctor: ____________________ Family Doctor: ____________________

Telephone: ____________________ Telephone: ____________________

Is this injury the result of a car accident? yes / no

Claim Number: ____________________ Date of Accident: ____________________

Adjuster: ____________________ Telephone: ____________________

Accuracy of Information

☐ I certify that the above medical information is correct to my knowledge

Privacy and Sharing of Information

☐ I authorize the clinic and its health professional to collect my personal and medical information as documented. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

Cancellation Policy

☐ Your appointment is reserved just for you. A late cancellation or missed visit leaves a hole in the therapists' day that could have been filled by another patient. As such, we require 24 hours notice for any cancellations or changes to you appointment. Patietns who provise less that 24 hours notice, or miss their appointment may be charged a cancellation fee.

Patient Signature ____________________ Date ____________________