EVERGREEN SPORTS & PHYSICAL THERAPY

1302 Bay Avenue
Trail, BC V1R 4A8

Brian Riemer PT
Noelle Rocheleau PT
Spencer Hachey, PT

Phone: (250) 368-8862
Fax: (250) 368-8887
Email: evergreenpt@shaw.ca

CLIENT INFORMATION

NAME_____ HOME PHONE _____

MAILING ADDRESS_____CITY_____ PROV_____ POSTAL CODE_____

WORK PHONE: _____ _____ **EMAIL**_____(for appointment reminders only)

FAMILY DOCTOR_____ REFERRAL SOURCE: (if family doctor write "same")_____

DATE OF BIRTH: YEAR _____ MONTH _____ DAY _____

BC SERVICES CARD/CARE CARD: _____

DO YOU HAVE EXTENDED BENEFITS? PACIFIC BLUE CROSS_____GREENSHIELD_____GREAT WEST LIFE_____ CHAMBER OF COMMERCE _____ MANULIFE _____ SUNLIFE (NOT TECK)_____

PLAN MEMBER NAME: _____

PLAN MEMBER DATE OF BIRTH (MM/DD/YYYY):_____

PLAN NUMBER: _____

CERTIFICATE//ID:_____

FUNDER INFORMATION

IF WORKSAFE OR ICBC CLAIMS ARE NOT ACCEPTED YOU WILL BE RESPONSIBLE FOR THE COST OF YOUR TREATMENTS BASED ON OUR PRIVATE RATES*

ICBC AND MSP – PREMIUM ASSISTANCE CLIENTS ARE CHARGED USER FEES. INQUIRE IF MORE INFORMATION IS NEEDED.

CLAIM NUMBER _____

DATE OF INJURY/ACCIDENT: month_____ day _____ year _____

PART OF BODY INJURED: _____ NAME OF CASE MANAGER/ADJUSTER_____

OCCUPATION _____ NAME OF EMPLOYER _____

CURRENTLY WORKING? YES_____ NO_____ IS FORM 8 COMPLETED? (required to start claim, filled out by GP) YES_____ NO_____

I HEREBY CONSENT TO TREATMENT AT EVERGREEN SPORTS AND PHYSICAL THERAPY AND HAVE UNDERSTOOD ALL INFORMATION ON THIS FORM AND AUTHORIZE ANY REPRESENTATIVE OF EVERGREEN SPORTS & PHYSICAL THERAPY TO CORRESPOND WITH ICBC, WORKSAFE BC, AND MY EXTENDED BENEFIT PLAN, VERBALLY OR IN WRITING IN REGARDS TO ANY ISSUE WHICH MAY RELATE TO MY THERAPY TREATMENT.

SIGNATURE_____DATE_____

CREDIT POLICY

As a service to our Clients, we may attempt to submit claims for payment to the Clients Insurance company, however, all payments for our services are the responsibility of the Client, and it is their responsibility to know all factors of coverage, including procedures and services not covered by insurance. Any and all disputes regarding insurance coverage are between the client and their Insurer.

IT IS UNDERSTOOD AND AGREED THAT OUR SERVICES ARE DUE IN FULL AT TIME OF SERVICE AND ALL SERVICES UNPAID AFTER TIME OF SERVICE ARE SUBJECT TO INTEREST AT RATE OF 2% PER MONTH WHICH THE CLIENT AGREES TO PAY.

_____ _____

Signature of Client Print Complete Name

NO SHOW POLICY

Patients who fail to show for their scheduled appointment will be granted one free no show. If they have not notified the office within 24 hours of their scheduled appointment time, they shall be subject to a "No Show/Cancellation" fee of $20.00 ****(Please note this is at the Physiotherapists discretion). In the event of an actual emergency and prior notice could not be provided, consideration will be given.

To cancel or reschedule appointments please call us at 250-368-8862 or email us at evergreenpt@shaw.ca

_____ _____

Signature of Client Date

CONSENT TO TRANSMIT INFORMATION ELECTRONICALLY

Personal Information

Personal information that we collect and communicate is used by your insurer and/or plan administrator for the purpose of assessing your claim and administering group benefits plan coverage. This includes payment of valid claims to you or to your healthcare provider and other designated person. Your insurer/plan administrator may exchange personal information about claims with you and a person acting on your behalf when necessary to confirm eligibility and to manage the claims.

Authorization and Signature

I authorize my healthcare provider(s) working with my insurer or plan administrator to exchange personal information when necessary for the above purposes. I understand that information may be subject to disclose to those authorized under applicable law within Canada. I authorize the exchange of personal information for the above purposes to be conducted electronically or in any other manner.

_____ _____

Signature of Plan Member Date