



Qualicum PHYSIOTHERAPY CLINIC

Pahl Physiotherapist Corp.

#1 - 140 West 1st Ave, Qualicum Beach, BC V9K 2R5
Phone: (250) 752-3212 Fax: (250) 752-3275
Email: qbphysio@shaw.ca

Cory Pahl, BMR,PT
Ezra Canfield, BSc, Kin, MSc.PT
Connor Malbon, MSc PT, MSc Kin

Please Note: We require 24 hours notice for appointment cancellations. There will be a \$15 charge for any missed appointments or late cancellations

- New Patient
 Returning Patient

NAME: _____

PHONE #: _____

ADDRESS: _____

DATE OF BIRTH: _____

City: _____

Postal Code: _____

CARE CARD # _____

CLAIM # _____

Occupation: _____

List of sports and/or recreational activities

TELL US WHAT AREA OF THE BODY NEEDS TREATMENT _____

X-RAYS, MRI'S OR ULTRASOUNDS TAKEN RELATED TO THIS INJURY..... YES NO

How did you hear about us? Doctor Newspaper Yellow Pages Website
 Friend/Relative - name _____ Other _____

Would you like to receive our monthly physiotherapy tips by e-mail – if yes, please provide your e-mail address

E-Mail Address _____

IF A MINOR, LIST GUARDIAN'S NAME & ADDRESS: _____

FAMILY DOCTOR: _____ SPECIALIST: _____

DO YOU PRESENTLY HAVE, OR EVER HAD ANY OF THE FOLLOWING (please indicate)

- | | | |
|--|---|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Dysfunction | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Hepatitis - A, B, or C (Please circle) | <input type="checkbox"/> HIV |

DO YOU HAVE ANY OTHER MEDICAL CONDITION _____

DO YOU HAVE A PACEMAKER..... YES NO

ARE YOU PREGNANT YES NO

MAJOR SURGERIES (include year) _____

MEDICATIONS (or what the medication is used for) _____

HAVE YOU VISITED PHYSIOTHERAPY, CHIROPRACTOR, MASSAGE THERAPY OR CHIROPODY ANYWHERE THIS YEAR?

YES NO If yes, how many treatments in total _____

I, _____ give permission for the therapist to discuss my treatment with my doctor or other health professionals when required, and for Qualicum Physiotherapy Clinic to request, receive or send any medical reports, results or notes when required.

Signature: _____ Date: _____

If you receive MSP premium assistance or are here under an ICBC or WCB claim, please complete reverse side of this form

All Health Care BC (MSP) Premium Assistance / WorkSafe BC (WCB) patients are required to sign the following 'Assignment of Payment' which authorizes our clinic to bill directly to Health Care BC / WorkSafe BC.

I, _____ (patient) authorize Health Care BC to pay Connor Malbon / Ezra Canfield / Cory Pahl, (Practitioners) directly for all reimbursements for benefits payable to me under the Medical and Health Care Services Regulation for care provided to me by said Practitioner. I make this assignment in full knowledge of the amount that I will be personally responsible for and the amount that will be reimbursed by Health Care BC, which will be directed to Ezra Canfield / Cory Pahl/ Connor Malbon (Practitioners) to be applied against any outstanding monies I owe for service provided.

Health Care BC Practitioner #'s Ezra Canfield – 50660 / Cory Pahl -46723/ Connor Malbon - 55733

This form allows the above-named Practitioner to receive your Health Care BC reimbursement directly for services that are Health Care BC benefits. Your Practitioner, by law, must advise you of his/her full fee and what portion will be reimbursed by Health Care BC. By agreement, your Practitioner may not charge you the portion reimbursable by Health Care BC.

Signature of Patient: _____ Patient's Name _____
Please print

Date: _____ Care Card # _____

HEALTH CARE BC – PREMIUM ASSISTANCE PATIENTS

Effective January 1, 2002 only MSP (Health Care BC) card holders who receive premium assistance are eligible for a combined annual limit of 10 visits which can include physiotherapy, massage therapy, chiropractic, naturopathy and non-surgical podiatry per calendar year. **Any visits over the 10 covered by MSP will be billed at the private rate. Therefore, it is critical that you tell us if you are having therapy elsewhere and have used any of the 10 visits.**

Signature _____

COST OF TREATMENT

Health Care BC requires us to inform you of the total cost of your treatment:

	Private Visits	Health Care BC Portion	Patient's Portion
Initial appointments	\$75.00	\$ 0.00	\$75.00
Subsequent appointments	\$70.00	\$ 0.00	\$70.00
Home Visitations	\$90.00	\$ 0.00	\$90.00
Patient with MSP premium assistance		\$23.00	\$45.00 1st visit / \$35.00 subsequent visits
Surcharge for IMS and Prolonged Appointments	\$10.00	\$0.00	\$10.00

ICBC (Motor Vehicle Claims) Date of Accident: _____ **Claim#** _____

Are you working with a lawyer -- Yes No

If you are working with a lawyer, please have them contact our office to discuss their requirements for us to correspond with ICBC.

Lawyer's Name: _____ Lawyer's Phone #: _____

I give consent for information regarding this injury to be shared with my legal counsel, ICBC adjustor, case manager or representative. **Signature** _____

Are you currently working? ___ Full-time ___ Part-time ___ Gradual Return to Work Program
Occupation _____

RCMP

Officer's Name _____ Health Identification # _____

Unit / Detachment _____ Division _____ Collator _____

Telephone # _____

Signature _____