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
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

NAME: _____ **PHONE #:** _____

ADDRESS: _____ **DATE OF BIRTH:** _____

CITY: _____ **CARE CARD #** _____

POSTAL CODE: _____ **CLAIM #** _____

OCCUPATION: _____ ☐ **Retired**

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 _____
E-Mail Address _____

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

FAMILY DOCTOR: _____ ☐ **NO DOCTOR** **SPECIALIST:** _____

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

☐ High Blood Pressure	☐ Thyroid Dysfunction	☐ Osteoporosis
☐ Heart Disease	☐ Diabetes	☐ Parkinson's Disease
☐ Cancer	☐ Rheumatoid Arthritis	☐ Fibromyalgia
☐ Lung Disease	☐ Hepatitis - A, B, or C (Please circle)	☐ 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 Supplementary Benefits or are here under an ICBC or WCB claim, please complete reverse side of this form

All Health Care BC (MSP) MSP supplementary benefits/ 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 and 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 Cory Pahl/ Connor Malbon (Practitioners) to be applied against any outstanding monies I owe for service provided.

Health Care BC Practitioner #'s 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 # _____

Claim # _____

HEALTH CARE BC – MSP supplementary benefits

Effective January 1, 2002 only MSP (Health Care BC) card holders who are qualify for Supplementary Benefits 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 _____

RCMP

Officer`s Name _____ Health Identification # _____

Unit / Detachment _____ Division _____ Collator _____

Telephone # _____ Signature _____

I give permission for Qualicum Physiotherapy to submit invoices through the Blue Cross Portal on my behalf.

For DVA and the CF

I authorize any requested information concerning my present health or injury, as well as any documentation related to this injury be provided to the Health Servies Centre or Blue Cross on behalf of VAC or CF. I

Signature: _____ K or CF Unit: _____

I give permission for Qualicum Physiotherapy to submit invoices through the Blue Cross Portal on my behalf.