Physiotherapy Client Information

Name ____

Date of Birth ____

Address ____

City ___________________________________ **Postal Code** __________________________________

Phone ____

Email address ____

Emergency Contact - Name ______________________________ **Phone** _________________________

Family Physician ____

How did you hear about us? ____

******Please complete information below if applicable******

BC Care Card #______________________________ **ICBC Claim #**______________________________

Extended Health #'s____

Please Note: **Your appointment time is especially reserved for you. If you cannot keep the appointment we require 24 hours cancellation notice. If we do not receive sufficient notice you may be charged a missed appointment fee of $70.00. We appreciate that you respect our time as much as we value yours.**

I have read and understand the above and agree to comply with the stated office policy:

____ **DATE:**________________________________

(PRINT NAME)

X____ **Guardian** _________________________

(SIGNATURE)