

NOSE CREEK SPORT PHYSICAL THERAPY REGISTRATION FORM

Name: _____ M / F Alberta Health Care # _____ - _____
(LAST) (FIRST) (MIDDLE INITIAL)

Guardian Info (18 and younger) Mother: _____ Father: _____

DOB: (M/D/Y) ____ / ____ / ____ Address: _____ Postal Code: _____

Res. Telephone: (____) _____ Bus. Telephone: (____) _____ Cell Phone: (____) _____

E Mail: _____ Emergency Contact/Phone #: _____

Family Dr. _____ Referring Dr. _____ Problem: _____

Employer: _____ Occupation _____

Is your condition work related? _____ WCB Claim? _____

Would you like to receive a courtesy appointment reminder? _____

Would you prefer an email or phone call for your courtesy appointment reminder? _____

IS YOUR CONDITION THE RESULT OF A RECENT **MOTOR VEHICLE COLLISION**? _____

Please have all the necessary information regarding your insurance to set up direct billing for your treatments. There are receipts provided for private payments. We accept cash, master card, visa and direct payment.

Date of Accident: _____ Policy/Claim Number _____

Insurance Company: _____

Adjuster Name: _____ Telephone: _____ Fax: _____

DO YOU OR YOUR SPOUSE HAVE ANY SUPPLEMENT **HEALTH CARE INSURANCE**? _____
COMPANY: _____ **PHYSICAL THERAPY COVERAGE:** Yes / No

The Calgary Health Region covers Fractures, Surgeries and Low Income. You will need to qualify.

If you have any of the following please circle:

Heart Disease, High Blood Pressure, Diabetes, Pregnancy, Metal Implant, Pace Maker, Other _____

HOW DID YOU FIND OUT ABOUT OUR CLINIC?

Dr. Referral (Name of Referring Dr. _____)

Other Health Care Professional (Name: _____)

Newsletter (Please Specify)

___ Your Healthy Lifestyle NCSPT Internet Newsletter

___ Coach/Team Name: _____

___ Previous Patient Name: _____

___ Friend/Relative Name: _____

___ Insurance Company Name: _____

___ Yellow Pages Name: _____

___ Other Name: _____

___ Walk in

___ Previous Patient

___ Employer

___ NCSPT Website

A **CANCELLATION FEE (\$25.00)** WILL BE CHARGED UNLESS THE CLINIC RECEIVES **24 HOURS NOTICE**. An answering machine will take your call after hours.

I _____ have read and understand the above information.

AUTHORIZATION

TO: NOSE CREEK SPORT PHYSICAL THERAPY (THORNCLIFFE)

RE: AUTHORIZATION TO DEBIT CREDIT CARD

I _____ hereby authorize **Nose Creek Sport Physical Therapy (Thorncliffe)** to debit to the under referenced credit card, any monthly charges for services performed on my behalf, any materials relating to those services and in the event that I cancel an appointment on less than 24 hours notice, a cancellation fee in the amount of **\$25.00**.

Type of Credit Card; MasterCard Visa

Date of Expiry; Month _____/Year _____

Credit Card Number:

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V Code: (3 numbers on the back of card)

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DATED AND executed this _____ day of _____,

Signature: _____