

Highway 410
D. Box 100
ie Verte, NL A0K 1B0

Patient Information

Name: _____

P.O. Box _____ Town _____ Postal Code _____

Home Phone: _____ Cell: _____ Work _____

Birth Date (DD/MM/YY) ____ / ____ / ____ Email: _____

Occupation: _____ Employer: _____

MCP: _____ Emergency Contact: _____

Family Doctor: _____ Referral Doctor: _____

Injured Area: _____ Date of Injury / Gradual Onset ____ / ____ / ____

Is your injury the result of a motor vehicle accident? YES NO

Automobile Insurance Company: _____

Ins. Adjuster: _____ Phone ____ / ____ / ____

Claim/Policy #: _____ Date of Accident ____ / ____ / ____

Is your injury covered under workers compensation? YES NO

Workers Compensation Contact Name: _____

Phone: ____ - ____ - ____ Claim#: _____

Employer: _____ Date of Accident (DD/MM/YY) ____ / ____ / ____

**If for any reason WHSCC declines your claim, you will be responsible to pay the outstanding balance*

Private Insurance

Primary Provider: _____ Policy/Plan#: _____ ID#: _____

Secondary Provider: _____ Policy/Plan#: _____ ID#: _____

Cancellation Policy

A "no show" is someone who misses an appointment without cancelling it by 10 am one working day in advance. Each "no show" will be recorded in the patients chart. For physiotherapy appointments an administrative fee of \$25.00 for each "no show" will be billed to the patients account. For massage therapy appointments, an administrative fee of \$40.00 for an hour appointment and \$25.00 for half hour appointment for each "no show" will be billed to the patients account.

By signing below, you confirm that you have read and understand this cancellation policy. For more information request to see Body Works Fitness' full cancellation policy.

Signature: _____ **Date:** ____ / ____ / ____
day / month / year