BROOKSWOOD PLUS Physiotherapy Clinic
4041 200 St, Langley, BC V3A 1K8 P: 236-325-0660 | Fax: 236-325-0600 www.plusphysio.ca

Patient Intake & Medical Consent Form

I. Patient Information

_____ _____ _____
(First Name) (Preferred Name) (Last Name)

Date of Birth: _____ Gender: | M | F | Other Personal Health No: _____
MM/DD/YYYY

Phone No.: _____ Email: _____

II. Emergency Contact Details

Full Name: _____ Relationship: _____Phone Number: _____

III. Primary Care Provider

Family Physician Name: _____ **Phone Number:** _____

IV. Insurance & Third-Party Claims: *Please complete the section below if it applies to your case:*

☐ **ICBC** **Date of Accident:** _____**Claim Number:** _____
MM/DD/YYYY

☐ **WSBC** **Date of Injury:** _____ **Claim Number:** _____
MM/DD/YYYY

☐ **Extended Health** _____ _____ _____
(Company) (Policy Number) (Member ID)

_____ _____ _____
(Policy Holder Name if not self) (Relation) (Policy Holder Date of Birth)

V. Agreements and Authorizations

1. Verification of Information I confirm that the details provided above are accurate and complete to the best of my knowledge. **Initials:** _____

2. Privacy & Information Disclosure I authorize **Brookswood Plus Physiotherapy** and its affiliates to share and obtain relevant medical records, reports, and diagnostic results. This disclosure includes communication with healthcare professionals, legal counsel, and insurance providers involved in my direct care or legal case. **Initials:** _____

3. Cancellation & No-Show Policy I acknowledge that a minimum of **24 hours' notice** is required to cancel or reschedule an appointment. Failure to provide notice or missing an appointment will result in the following charges to the credit card on file: **Massage** (Full Price); **Other Services** ($50). **Initials:** _____

4. Informed Consent for Treatment I hereby consent to physical examinations and treatments administered by certified practitioners at Brookswood Plus Physiotherapy. I understand that my care may involve exercise equipment as well as various physical and electrical therapeutic modalities. **Initials:** _____

_____ _____
(Signature) (Date MM/DD/YYYY)