BONAVISTA PHYSICAL THERAPY (WCB INTAKE)
739 LAKE BONAVISTA DR. SE
CALGARY, AB T2J 0N2

PLEASE PRINT E-mail Address____________________________

Name______________________________________ Birth Date M____ D____ Y_______
(last) (first) (middle initial)

AHC#___________-___________ Age____ Family Physician ________________________
(first initial & surname)

Home Address_____________________________________ Male ____ Female _________

City________________ Province____ Postal Code _________WCB Claim # ____________

Primary # ______________ work # _____________ Date of Accident __________________

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EMPLOYER INFORMATION

Job Title/Occupation ____

Company Name ____

Address ____

City _____________ Prov _____ Postal Code _____________ Phone No. _______________

Which practitioner or facility rendered first treatment ________________________________

____Date ____________________________

Have you had previous physiotherapy in the past year?______________________________

If yes, where and when: ____

Were you referred to Bonavista Physical Therapy? ____________________________

If yes, by whom: ____

If no, how did you hear about us? ____

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Physiotherapists practice within a code of ethics, and a privacy policy is in place.

- In case of an emergency in this office, your therapist or another staff member will inform you of evacuation procedures.
- I understand that I am able to decline treatment at any time.
- I am aware that there is a grievance procedure and that I can appeal decisions regarding my care in case I am not satisfied with the service.
- I will allow Bonavista Physical Therapy Clinic to communicate with my physician, my radiologist, the Worker's Compensation Board and my employer regarding my condition.
- I understand that if Worker's Compensation Board does not accept responsibility for the claim, I will be responsible for the cost of treatment.
- I am responsible for any fees incurred due to missed appointments or cancellation under 12 hours notice.
- **If you were not sent here by WCB please supply your VISA or MC numbers as insurance in the case the claim is not accepted.**

Please sign in space provided in acknowledgement and understanding of the above.

Signed ______________________________________ Date ________________________