EVERGREEN SPORTS & PHYSICAL THERAPY

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CLIENT INFORMATION

NAME_____ HOME PHONE _____

MAILING ADDRESS_____CITY_____ PROV_____ POSTAL CODE_____

WORK PHONE: _____ _____ EMAIL_____

FAMILY DOCTOR_____ REFERRAL SOURCE: (if family doctor write "same")_____

DATE OF BIRTH: YEAR _____ MONTH _____ DAY _____

BC SERVICES CARD/CARE CARD: _____

DO YOU HAVE EXTENDED BENEFITS? PACIFIC BLUE CROSS_____GREENSHIELD_____GREAT WEST LIFE_____
CHAMBER OF COMMERCE _____ MANULIFE (NOT FORTIS)_____ SUNLIFE (NOT TECK)_____

FUNDER INFORMATION

IF WORKSAFE OR ICBC CLAIMS ARE NOT ACCEPTED YOU WILL BE RESPONSIBLE FOR THE COST OF YOUR TREATMENTS BASED ON OUR PRIVATE RATES*

ICBC AND MSP – PREMIUM ASSISTANCE CLIENTS ARE CHARGED USER FEES. INQUIRE IF MORE INFORMATION IS NEEDED.

CLAIM NUMBER _____

DATE OF INJURY/ACCIDENT: month_____ day _____ year _____

PART OF BODY INJURED: _____ NAME OF CASE MANAGER/ADJUSTER_____

OCCUPATION _____ NAME OF EMPLOYER _____

CURRENTLY WORKING? YES_____ NO_____ IS FORM 8 COMPLETED? (required to start claim, filled out by GP) YES_____ NO_____

I HEREBY CONSENT TO TREATMENT AT EVERGREEN SPORTS AND PHYSICAL THERAPY AND HAVE UNDERSTOOD ALL INFORMATION ON THIS FORM.

SIGNATURE_____DATE_____