



## EVERGREEN SPORTS & PHYSICAL THERAPY

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Trail, BC V1R 4A8

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### CLIENT INFORMATION

NAME \_\_\_\_\_ HOME PHONE \_\_\_\_\_

MAILING ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ PROV \_\_\_\_\_ POSTAL CODE \_\_\_\_\_

WORK PHONE: \_\_\_\_\_ EMAIL \_\_\_\_\_ (for appointment reminders only)

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) \_\_\_\_\_

PLAN MEMBER NAME: \_\_\_\_\_

PLAN MEMBER DATE OF BIRTH (MM/DD/YYYY): \_\_\_\_\_

PLAN NUMBER: \_\_\_\_\_

CERTIFICATE//ID: \_\_\_\_\_

### 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 AND AUTHORIZE ANY REPRESENTATIVE OF EVERGREEN SPORTS & PHYSICAL THERAPY TO CORRESPOND WITH ICBC, WORKSAFE BC, AND MY EXTENDED BENEFIT PLAN, VERBALLY OR IN WRITING IN REGARDS TO ANY ISSUE WHICH MAY RELATE TO MY THERAPY TREATMENT.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**CREDIT POLICY**

As a service to our Clients, we may attempt to submit claims for payment to the Clients Insurance company, however, all payments for our services are the responsibility of the Client, and it is their responsibility to know all factors of coverage, including procedures and services not covered by insurance. Any and all disputes regarding insurance coverage are between the client and their Insurer.

IT IS UNDERSTOOD AND AGREED THAT OUR SERVICES ARE DUE IN FULL AT TIME OF SERVICE AND ALL SERVICES UNPAID AFTER TIME OF SERVICE ARE SUBJECT TO INTEREST AT RATE OF 2% PER MONTH WHICH THE CLIENT AGREES TO PAY.

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Print Complete Name

**NO SHOW POLICY**

Patients who fail to show for their scheduled appointment will be granted one free no show. If they have not notified the office within 24 hours of their scheduled appointment time, they shall be subject to a "No Show/Cancellation" fee of \$20.00. \*\*\*\*\* (Please note this is at the Physiotherapists discretion). In the event of an actual emergency and prior notice could not be given, consideration will be given.

To cancel or reschedule appointments call us 250-368-8862 or email us at evergreenpt@shaw.ca.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

**CONSENT TO TRANSMIT INFORMATION ELECTRONICALLY**

**Personal Information**

Personal Information that we collect and communicate is used by your insurer and/or plan administrator for the purpose of assessing your claim and administering group benefits plan coverage. This included payment of valid claims to you or to your healthcare provider and other designated person. Your insurer/plan administrator may exchange personal information about claims with you and a person acting on your behalf when necessary to confirm eligibility and to manage the claims.

**Authorization and Signature**

I authorize my healthcare provider(s) working with my insurer or plan administrator to exchange personal information when necessary for the above purposes. I understand that information may be subject to disclose to those authorized under applicable law within Canada. I authorize the exchange of personal information for the above purposes to be conducted electronically or in any other manner.

\_\_\_\_\_  
Signature of Plan Member

\_\_\_\_\_  
Date