

**SABER PHYSIOTHERAPY INITIAL ASSESSMENT**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Name: |  | | Date of Birth: | |  | Age: |  |
| Mailing Address: |  | | | | | | |
| City: |  | Postal Code: | |  | | | |
| E-mail Address: |  | Phone (Cellular): | |  | | | |
| Phone (Home): |  | BC Care Card #: | |  | | | |
| Occupation: |  | ICBC Claim # (If applicable) | |  | | | |
| Family Physician: |  | Appointment Confirmation Preference: | | * Email * Text (SMS) Message * Phone call | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Description of Injury (Optional): | |  | | | |

**We may be able to directly bill certain insurance providers (Pacific Blue Cross, Manulife, Great West Life, Sunlife Financial, etc.) Please provide your extended healthcare provider plan information on the Extended Healthcare Billing Form to see if your plan qualifies for coverage.**

**\*\*Based on therapist discretion, there may be a charge for a missed appointment.\*\***

**\*\*Unpaid appointments will be subject to a 5% interest rate per month after sixty days.\*\***

**Consent to Treatment:**

I have completed this form to the best of my knowledge and I consent to treatment for my condition. I understand there is always a risk associated with any treatment provided and that I have a right to refuse any treatment option.

* **I AGREE TO THE ABOVE TERMS AND CONDITIONS**

**DATE OF AGREEMENT:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_