inMotion NETWORK

Physiotherapy Clinics and More

inmotionnetwork.ca

❑ Physiotherapist ❑ Massage Therapist ❑ Foot Care Nurse ❑ Sports Medicine
❑ Chiropractor ❑ Athletic Therapist ❑ Dietician ❑ Personal Trainer

PATIENT INFORMATION

Name: ______________________________

Mailing Address: ______________________________

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Date of Birth: ______________________________

Employer: ______________________________

PHIN #: ______________________________

Date: ______________________________

Telephone: (H) ______________________

(W) ______________________

(C) ______________________

E-Mail: ______________________________

MB Health #: ______________________________

Referring Physician:

Doctor's Name: ______________________________

Doctor's Phone #: ______________________________

Family Physician:

Doctor's Name: ______________________________

Doctor's Phone #: ______________________________

Consent for Treatment / Release of Medical Information:

I, the undersigned, give consent to the inMotion Network to assess and begin treatment. I also authorize the release of pertinent medical information to my physician and case managers / adjusters in the case of a MPI / WCB claim or private insurance claim.

Signature: ______________________________

Signature: ______________________________
(Guardian if under 18)

BILLING INFORMATION:

❑ Blue Cross Group #: ______________ Contract #: ______________

❑ DVA / RCMP / DND Group (K) #: ______________ Authorization #: ______________

❑ MPI Claim #: ______________ Adjuster: ______________

❑ WCB Claim #: ______________ Case Manager: ______________

❑ Private Insurance Type: ______________ Policy #: ______________ ID #: ______________

❑ No Insurance

Name of policy holder (if not same as patient): ______________________ D.O.B.: ______________

Relationship to patient: ______________________________

Notice: Service fees are the responsibility of the patient. Payment is due after each treatment unless otherwise arranged. Patients covered by MPI or WCB are not responsible for payment unless there is difficulty in collecting from the applicable agency. A $10 annual administration fee will be applied for direct billing privileges when possible to private insurance companies. It is the patient's responsibility to keep track of their number of visits related to insurance coverage maximums. Failure to provide 24 hours notice of cancellation will result in a $35 no show fee. I, the undersigned, acknowledge and understand the above content.

Signature: ______________________________

Signature: ______________________________
(Guardian if under 18)