YOUR CENTRES FOR SPINAL, SPORTS AND OCCUPATIONAL REHABILITATION

www.PantherSportsMedicine.com

PHYSIOTHERAPY REGISTRATION

Please print

Last Name: ________________________________ First Name: ________________________________

Gender: ☐ Male ☐ Female ☐ Optional Gender Information: _________________________ Preferred Pronoun: ________

Address: ____ Date of Birth: ____/____/______
mm dd yyyy

City: _________________________ Prov.: _________________ Postal Code: _________________

Phone #: (hm.) _______________________ (wk.) ______________________ (cell.) _______________________

Email Address: ____ ☐ Consent to receive e-mails

Referring Physician: _______________________________ Alberta Healthcare Number: ______________-____________

Family Physician: _________________________________ Medical Clinic: ______________________________________

Do you have extended Health Care? ☐ yes ☐ no Insurance Company: ________________________________

Name of Insured: __________________________________ Insured Date of Birth: ______________________________

Policy/Group #: __________________________________ Certificate/ID #: __________________________________

Is this injury from a Motor Vehicle Accident? ☐ yes Claim #: ____ ☐ no

Date of Accident: __________________________ Insurance Company: ____________________________________

Is this injury a Workers' Compensation claim? ☐ yes Claim #: ____ ☐ no

Date of Accident: _____________________ Employer: ____

Is this injury related to: ☐ Surgery ☐ Fracture Date of Surgery/Fracture: ______________________

• Physical Therapy • Sports Medicine Physician • Orthopaedic Surgeon • Acupuncture/IMS • Orthotics/Bracing • Massage Therapy • Vestibular Therapy

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Client Privacy Policy & Consent

The Panther Sports Medicine and Rehabilitation Centres are committed to controlling and protecting the collection, use and disclosure of the personal information provided by its patients. Our policy is guided by the Canadian Standards Association Model Code and synthesizes relevant material from the Protection of Personal Information Protection and Electronic Documents Act (PIPEDA), Personal Information Protection Act (PIPA), and Health Information Act (HIA). A complete copy of Panther Sports Medicine & Rehabilitation Privacy Policy is available on the Panther Sports Medicine website at: www.PantherSportsMedicine.com.

Patient Authorization

I, ____, the patient/parent/guardian, hereby agree to the following:

Consent for treatment and Authorize Panther Sports Medicine to Release Health Information (status and progress) to my medical practitioner, insurance company, WCB, employer, lawyer or their representative as needed for my treatment episode. I understand and authorize that this information may be exchanged electronically on my behalf.

Fees for Treatment: To pay any outstanding fees incurred for therapy.

Benefits Assignment and Consent: I hereby assign benefits payable for my eligible claims to Panther Sports Medicine for submitting electronically to my group benefits plan and I authorize the insurer to issue payment directly to Panther Sports Medicine. I understand the insurer is under no obligation to accept this assignment. I agree that this assignment will apply to all eligible claims submitted electronically by the provider. If I am a spouse, I confirm that I am authorized by the plan member to assign benefit of payments to Panther Sports Medicine. In the event that claims are denied I understand that I remain responsible for payment to the provider for any services rendered.

Dated on __________ day of, ___________________________, 20____.

Patient Signature: ____
(signature of parent or legal guardian required if patient is less than 18 years old)

Please tell us how you came to our clinic (please specify where applicable):

❑ Physician referred me to Panther Sports ❑Previous Panther Patient ❑ Social Media
❑ AD/Newsletter ❑ Website/Internet ❑ Signage ❑ Services within Building
❑ Law Firm ❑ Insurance Company ❑ Friend/Family/Team ___________________________

***To reschedule an appointment, we require 24 hours notice. Otherwise, a late cancellation or no show fee may be charged.**

"Take the leap to good health"

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