PURE PELVIC HEALTH

New Client Information

NAME:	DATE:
ADDRESS:	CITY:
PROVINCE:	POSTAL CODE:
PHONE #:	CELL #:
DATE OF BIRTH:	EMAIL:
PREFER REMINDERS VIA:	PHONE / CELL / EMAIL
EMERGENCY CONTACT:	RELATIONSHIP TO YOU:
EMERGENCY CONTACT PHONE:	HEALTH CARD NUMBER:

Referral Source

NAME:	Family Doctor / Specialist / Other Health Professional: _______________
PHONE:	FAX:

Family Doctor

PHYSICIAN'S NAME	
PHONE:	FAX:

IMPORTANT CHANGES TO ELECTRONIC COMMUNICATION

Canada's Anti-Spam Legislation (CASL) requires us to obtain your written consent before we send you any communications by email.

Please take a moment to provide your email address and your consent so that we may contact you via email.

Name: ____

Email: ____

- ☐ **Yes, I consent to receiving email communication from Pure Pelvic Health.**

Thank you for your permission. We may occasionally contact you to:

- Request your feedback regarding the service you have received from Pure Pelvic Health
- Provide you with an invoice, receipt, or other billing related information
- Provide you with valuable information relating to insurance coverage or changes in legislation affecting Physiotherapy and other rehabilitation and wellness services
- Provide you with valuable health and rehabilitation information
- Inform you about current promotions and offers from Pure Pelvic Health (i.e., massage deals, orthotics promotions, etc.)

If you change your mind, you can easily remove your email at any time.

Health History

Are you currently under medical care for any of the following or have a history of any of the following:

☐ Heart disease	☐ Fainting or dizziness
☐ High/low blood pressure	☐ Headaches/migraines
☐ Diabetes	☐ Osteoporosis
☐ Cancer	☐ IBS
☐ Endometriosis	☐ Other: ________________________

CANCELLATION POLICY

While we understand that unexpected situations arise that may require a client to cancel an appointment, please understand that due to the nature of our business it is difficult to place another client in a cancelled appointment time.

Therefore, please be advised that we require a minimum of 24 hours notice to cancel an appointment. Last minute cancellations or "no shows" will be billed directly to the client at the following rates:

Cancelled/Missed appointment……………….$50.00………...billed to client

CLIENT ACKNOWLEDGMENT OF CANCELLATION POLICY:

Date: ____

Client Signature: ____

Pure Pelvic Health Representative: _________________________________

PAYMENT OF ACCOUNT CONTRACT

The client of Pure Pelvic Health accepts final responsibility for paying for all provided goods and services at Pure Pelvic Health's prevailing and published rates. Please review signs posted in our waiting room for current rates. If you have any questions, please do not hesitate to ask any Pure Pelvic Health staff member.

Your extended health plan is a contract between you and the insurance company, not between the company and Pure Pelvic Health. As the patient, you alone authorize your Pure Pelvic Health therapist to treat you. As such, you are solely responsible for the payment of the fees including those that are not covered by your extended health insurance.

CLIENT ACKNOWLEDGMENT OF PAYMENT OF ACCOUNT

Date: ____

Client Signature: ____________________________________

Pure Pelvic Health Representative: _______________________