Alpha Physical Rehabilitation & Health Center Ltd.
General Information and Consent Form

Name _____ Today's Date _____
Address _____ Birthdate _____
_____ Health Card _____
Home Number _____
Mobile Number _____ Family Physician _____
Email _____ Referring Physician _____

Insurance Direct Billing

Insurance Company _____
Member ID / Certificate _____ Plan / Policy No _____
Primary Holder Name _____ Primary Holder Birthdate _____

WCB / SGI Claim

Claim No _____ Employer Name _____
Date of Injury _____ Employer Phone _____
Supervisor Name _____ Employer Fax / Email _____

How did you hear about us?

- ☐ Google
- ☐ Word of Mouth
- ☐ Social Media
- ☐ Other
- ☐ Location
- ☐ Doctor referral
- ☐ Previous Patient

Initial

I authorize the release of information to my family and/or referring physician about my treatment. _____

I, (or guardian of patient under 18 years), authorize the therapist to use any necessary medical treatments and modalities for my condition. I consent to being touched for medical reasons as needed. _____

Our contracts with WCB and SGI dictate that we report all missed treatment appointments to them, regardless of notice given or not. _____

I understand that 12 hours notice is required for cancellations, without which the full fee will be charged. This notice will help us serve all our clients better. _____

Signature _____

Office Use Only

Family Physician T _____ Referring Physician T _____
Family Physician F _____ Referring Physician F _____
Additional Employer Details _____
WCB / SGI CSR Name _____ Phone / Extn _____