



Client Name (please print): _____
(As Written on your Care Card)

Preferred Name _____

Date of Birth: ____/____/____ Home Phone: () _____
Day / Month / Year

Care card: _____ Work/Cell Phone: () _____

Address: _____ City: _____ Postal Code _____

***Would you allow Parkway Physiotherapy + Performance Centre to contact you via email?**

If YES, provide your email _____

*** Would you allow Parkway Physiotherapy +Performance Centre to contact your doctors with respect to your medical information?**

If YES, please provide:

Family Doctor: _____ Phone: () _____

Specialist: _____ Phone: () _____

Specialist: _____ Phone: () _____

Specialist: _____ Phone: () _____

Treatments are paid directly by the patient unless ICBC, Medical Services Plan, WorkSafeBC or an additional Third Party Payer provides approved coverage. A user fee will be charged on all ICBC and MSP premium assistance visits.

Parkway Physiotherapy has a 24-hour cancellation policy. If you are unable to attend your appointment, please give at least 24 hours notice, or you will be responsible for paying a \$25.00 non-refundable reservation fee.

I have read and understood the above:

Signature: _____ Date: ____/____/____
Day / Month / Year

Please help us spread the word about Parkway Physiotherapy + Performance Centre by letting us know how you heard about us. Please Circle One

Sandwich Board/Drive By
Television: Chek TV/Advertisement
Goldstream Gazette
Community Event/Sports/Talk
Radio – The Ocean
Friend/Family _____

Yellow Pages
Internet – Blog/FaceBook
Doctor _____
Specialist _____
HealthCare Team _____
Other _____