SOUTHCENTRE
HEALTH & WELLNESS

CONFIDENTIAL PATIENT INFORMATION

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Registered Massage Therapist

Name: ____________________

Address: ____________________

City: ____________________ Province: ______________ Postal Code: ______________

Home Phone: ____________________ Cell Phone: ____________________

E-Mail Address: ____________________

Date of Birth: ______________ Sex: ______________ Height: __________ Weight: ______________
(DD/MM/YY)

Employer: ____________________ Occupation: ____________________

Alberta Health Care #: ____________________ Marital Status: ____________________

Family Physician: ____________________

Emergency Contact: ____________________ Phone: ____________________

How would you like to receive your appointment reminders: __Email __Text*_
**CELL PHONE PROVIDER (required for TEXT reminder)* __Bell __Telus __Fido __Koodo __Virgin __Rogers __PC Mobile

How did you hear about our office? ______________ If referred, who can we thank? ______________

Have you received massage therapy before? __ No __ Yes
Females: Are you pregnant __No __Yes: How many weeks_____

Please list any medications you may be taking: ____________________

Is this a motor vehicle accident case? __No __Yes Date of Injury: ______________

Is this a Workers' Compensation Board case? __No __Yes: Date of Injury: ______________

Major Complaints/Symptoms: ____________________

When did this problem begin? ____________________

Please check if you are currently or have experienced any of the following:

__ High blood pressure
__ Heart disease
__ Blood clotting disorders
__ Any contagious diseases
__ Bursitis
__ Low blood pressure
__ Allergies
__ Skin problems
__ Joint problems
__ Back and/or neck pain
__ Stress
__ Circulatory problems
__ Diabetes
__ Bone disease
__ TMJ Dysfunction
__ Headaches
__ Arthritis
__ Seizures
__ Inflammation
__ Other: ____________________

What other Southcentre Health and Wellness services are you interested in?

__ Massage Therapy __ Acupuncture __ Custom Foot Orthotics

INFORMED CONSENT FOR MASSAGE

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Registered Massage Therapist

I understand that massage is given here for the purpose of stress reduction, relief from muscular tension, muscle spasm or pain, and/or for increasing circulation.

I understand that the massage therapist does not diagnose illness, disease or any other physical or mental disorder. As such, the massage therapist does not prescribe medical treatment or pharmaceutical treatment, nor do they perform manipulations. It has been made clear to me that massage is not a substitute for medical examination or diagnosis and that it is recommended that I see a physician for any physical ailment I might have.

I have stated all my known conditions and take it upon myself to keep the massage therapist updated on my physical health.

I understand that there will be a full charge on all missed appointments or cancellations without 24 hours notice.

I understand that payment is expected at the time of treatment.

Date this _____day of _____________________, 20________.

______________________________	______________________________
Patient/Legal Guardian Signature	Witness Signature
______________________________	______________________________
Patient Name (please print)	Witness Name (please print)

NOTE: Please remove any jewelry from the area being massaged. If you wear contact lenses or dentures, it is recommended that you remove them for your own comfort.

Ph: 403.271.1081 | **Fax:** 403.271.4913
173 Southcentre Mall | 100 Anderson Road S.E. Calgary, Alberta | T2J 3V1

SOUTHCENTRE HEALTH & WELLNESS

Office Financial Policy

Cancellation Policy

The time you have booked for your appointment is valuable. If you will not be able to attend a scheduled appointment, it is your responsibility to call the office with at least 24 hours notice to reschedule it. Failure to do so will result in 100% of the appointment cost being charged to you.

Direct Billing

Insurance Company___________________________ Name of Plan Holder_______________________________

ID #____ Policy#____

I hereby assign benefits payable for the eligible claims to the Provider responsible for submitting my claims electronically to the group benefits plan and I authorize the insurer/plan administrator to issue payment directly to the Provider. In the event my claim(s) are declined by the insurer/plan administrator, I understand that I remain responsible for payment to the Provider for any services rendered and/ or supplies provided.

Date: ________________________________

_______________________________________ _______________________________________

Patient Signature (Legal Guardian) Witness Signature

_______________________________________ _______________________________________

Patient Name (please print) Witness Name (please print)

Appointment Reminders

Please understand that it is your responsibility to keep booked appointments. As a courtesy we offer email/text message reminders. If for whatever reason you do not get a confirmation by text or email, it is still your responsibility to be on time for this appointment.

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CREDIT CARD INFORMATION

__Visa __Mastercard

Card Number ____CardExpiry_________________________

Signature____

ALL HARD COPIES OF CREDIT CARD INFORMATION WILL BE DESTROYED ONCE ENTERED INTO OUR COMPUTER TO ENSURE YOUR INFORMATION IS KEPT SECURE.

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