

## PATIENT INFORMATION

Name:	Home #:	-	-	Cell #:	-	-
Address:	City:			Postal Code:	-	
E-mail:	Occupation:					
Date of Birth (dd/mm/yyyy):						
Family/Referring Dr.:						
Emergency Contact Name:				#:	-	-

## PAYMENT POLICY

### FEES: *Physiotherapy*

Initial Assessment/Consultation

\$125.00

Subsequent Treatments

\$80.00

### FEES: *Pelvic Floor*

Initial Assessment/Consultation

\$150.00

Subsequent Treatments

\$85.00

If the services provided are not covered by my insurance, employer or other third party, I understand that I am responsible for paying any outstanding balance including deductibles.

If you would like FreeFlo Physiotherapy to direct bill your insurance company, I understand that my credit card will be kept on file to cover any outstanding balances. You will be notified prior to any charges to the credit card.

Credit Card Type/Number: \_\_\_\_\_ Exp: \_\_\_\_\_ CVC: \_\_\_\_\_

FreeFlo respectfully requires patients to provide 24 hours notice for appointment cancellations. Consequently, I acknowledge that if I do not provide 24 hours notice, I may be charged a cancellation fee (not payable by insurance).

Signature: \_\_\_\_\_

## COMMUNICATION AND CONSENT TO RELEASE INFORMATION

I, \_\_\_\_\_ authorize FreeFlo Physiotherapy to release/obtain information from the following, regarding my care by phone, fax, email, report, letter or direct communication.

Physician(s)  Insurer  Employer  Diagnostic imaging

Signature: \_\_\_\_\_