RISE Health
1275 Bay Street
Victoria BC V8T 1S8
PH: (250) 381-7473

Intake Form

Name:____ Sex: ☐Male ☐Female ☐Other

Date of birth (yyyy/mm/dd)______________________________ Age: __________________________

Home #:__________________ Work #:________________ Cell #: ______________________

Email: ____

An email reminder will be sent the day before your scheduled appointment.

Address:____

City/Province:______________________________ Postal code: __________________________

BC Care Card Number: ____

Reasons for seeking treatment? ____

How did you hear about our clinic?____

Emergency Contact Information

Contact Name: ____

Relationship: _______________________________________ Ph: ____________________________

☐ Would you like to receive Practitioner Updates, New Services Announcements and Newsletters from RISE Health?

**The anti-spam legislation requires that we ask for your consent to send you emails.*

Office Policy:

In consideration of other patients and my therapist, I understand that a minimum of 24 hours' notice is required to change or cancel my appointment. I am aware that I am responsible for paying the full treatment fee in the case of late cancellation or missed appointments.

I understand and agree that the cost of treatment is my responsibility, should private insurers (MSP, ICBC, DVA, WCB or other providers) fail to reimburse the clinic for services provided. All outstanding accounts over 60 Days are considered overdue and will be charged at a rate of 25% per annum.

Please note this is a scent free environment.

________________________ ________________________
Signature **Date**