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 #: _____

Please indicate if it is ok to leave a messages at the contact phone numbers above? Yes _____ No_____

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 Name: _____

Ph: _____ Relationship: _____

☐ 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' (excluding weekends) 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.

□ To ensure Rise Health provides the highest level of care to our patients and fulfils the collaborative care model we strive to provide, you agree that all treating practitioners will be permitted to access and discuss your Rise Health charts when necessary and provided such access is in accordance with our privacy policy.

□ I understand that this is a scent free facility.

□ **Treatment Consent:** I hereby consent to treatments including the use of manual therapy techniques and exercise rehabilitation. I understand there may be some discomfort from the rehabilitation depending on the injury and I agree to inform the therapist should any additional symptoms occur. I understand that all exercise programs place a workload on the body to promote improvement and at the same time present the risk of negative body response to that exercise. I understand that the therapist will do their best care to properly progress, monitor and care for my injuries.

Signature: _____ Date: _____