SUNSET PHYSIOTHERAPY

Acupuncture Registration Form

Last name: _____ First name: _____

Date of Birth: month____/day____/year____ Occupation: _____

CareCard Number: _____

Address: _____ City: _____

Postal Code: _____ Cell#:/carrier: _____

Home Phone#: _____ Email: _____

Family Doctor: _____ Phone#: _____

Chief Complaint: _____

Your Physician's Diagnosis: _____

1. Have you ever been treated with Acupuncture and/or Herbal Therapy?
Circle: NO/YES → When and how long? _____ Diagnosis ? _____

2. Are you currently taking any medication? Or using any blood thinning drugs?
Circle: NO/YES → Name: _____

3. Do you regularly use the following? NO/ if YES, how often?
Cigarettes: _____ Alcohol: _____ Drugs: _____

4. Are you a vegetarian? Circle: NO/YES

5. Are you pregnant? Circle: NO/YES _____ Week(s)

6. Have you ever been hospitalized and/or treated for any infectious or serious diseases/illnesses?
Circle: NO/YES → Details: _____

7. Do you have any allergies? Circle: NO/YES → Details:_____

8. Do you have any family history of health problems? Circle: NO/YES
Details: _____

I certify that all of the information on this form provided by me is true and accurate, and I consent to be treated accordingly.

_____ _____

Date Patient's Signature

SUNSET PHYSIOTHERAPY

Acupuncture Fees

Please read and mark accordingly!!!

☐ **ICBC CLAIM**
Clients with ICBC coverage for Acupuncture will be responsible for paying full amount for the treatment at the private rate (listed below). You can submit your receipts for reimbursement.

☐ **WCB CLAIM**
Clients filing WCB claims will pay the **private** rate until the case has been accepted for coverage by the board. Fees paid will be reimbursed to the client by the clinic once the payment has been collected from the WCB.

☐ **PRIVATE**

Initial consultation without treatment _____	**$35.00**
Initial consultation with treatment _____	**$85.00**
Follow-up treatment _____	**$70.00**
Cupping_____	**$50.00**

If you have extended medical insurance we can bill directly your insurer and you will be responsible for the portion that is not covered. If we can't bill your insurer directly you can submit your receipts to your insurer to be reimbursed the covered portion of your costs. **Non-reimbursed fees qualify as a medical deduction for tax purposes.**

☐ **STUDENT**
The initial and each follow up visit_____ **$45.00**
You must have a **valid student ID card**.

☐ **PREMIUM ASSISTANCE MSP**
Clients with Premium Assistance MSP coverage receive up to 10 subsidized visits per year_____ **$25.00** per visit

☐ **CANCELLATION POLICY**
Please provide 24 hour advanced notice to cancel or reschedule.
There is a **$25.00 cancellation fee** for failure to attend a scheduled appointment without providing sufficient notice.

All applicable taxes are included in the above amounts.
All fees are subject to change without notice.

_____ _____
Date Patient's Signature