KINSMEN SPORTS CENTRE
PHYSICAL THERAPY CLINIC

INTAKE FORM

NAME:_____
(Last) (First) (Middle initial)

ALBERTA PERSONAL HEALTH NUMBER: __ __ __ __ __ - __ __ __ __

DATE OF BIRTH: ____/_____/_____ **AGE**:_____
Day / MM / Year

ADDRESS: _____

_____
(City) (Province) (Postal code)

TELEPHONE: HOME _____ **WORK/CELL** _____

E-MAIL:_____
Please indicate your interest in the following services:

☐**I would like email reminders of my appointments** ☐**I am interested in receiving a clinic newsletter (quarterly)**

Please initial here indicating you have read the Missed Appointment and Respecting Your Privacy Documents _____

Referring Physicians Name (if applicable):_____

Emergency Contact Person:_____Phone:_____

Have you had physical therapy for this body part? No_____Yes_____Clinic:_____Date:_____

Did you have surgery for this injury or fracture a bone? No___Yes____Doctor_____When:_____

If a fracture, when was the cast removed? _____

Is this a Workers' Compensation Case? No_____Yes_____WCB CLAIM #_____

Was this injury a result of a Motor Vehicle Collision? No_____Yes_____If so, please provide the following:

Date of Accident: _____Insurance Company:_____

Adjustor's Name:_____Adjuster's Phone #_____AB Forms Completed:_____

Do you have any of the following?

Heart Disease_____Metal Implant_____High Blood Pressure_____Diabetes_____Pace Maker_____
Drug Allergies:_____Other:_____

- The Alberta Health Services (AHS) Ambulatory Community Physical Therapy (ACPT) program may provide assessment and limited treatment coverage for those patients who have had recent surgery or a fracture, a severe injury according to the determination of need form (DON), or meet low income eligibility requirements. If you do not qualify for ACPT funding the treatment fee is $80.00.
- Patients without Alberta Personal Health Numbers, or those previously assessed in the AHS ACPT current fiscal year for the same injury, will be required to pay privately, as per the posted fee schedule.
- My signature below acknowledges my understanding of my liability for any costs incurred by me at this office. Payment options include Interac, Visa, Mastercard, cash, or cheque.
- My signature below also permits disclosure of information relating to my attendances to Extended Health Benefit Providers for the purposes of confirming my attendance and the nature of my submitted claim.
- If you have any questions throughout the course of your physiotherapy sessions, please do not hesitate to discuss them with your physiotherapist or Clinic personnel.

Conditions of Service Directions as indicated by the Alberta Health Services
I understand the assessment to be completed by the Kinsmen Sport Centre Physical Therapy Clinic will determine my eligibility to have physical therapy services paid for by AHS ACPT Services. I also understand the information collected about me during the assessment may be disclosed to AHS for the purpose of payment for my physical therapy and the evaluation of the care provided. I understand if I have any physical therapy treatment paid for by the AHS ACPT program, my personal clinical information may be used for ACPT review and improvement. Health information and Personal Health Number are being collected under the authority of sections 20 (b) and 21(1) of the Health Information Act.

Signature_____ Date:_____
If under 18 years must be signed by parent/guardian