Patient Intake Form

Please print clearly. If you have any questions, please ask our staff. Thank you.

PERSONAL INFORMATION

Legal Name

Chosen/Preferred Name (if applicable) — First Name — Middle Initial — Last Name

Address:

City: Province: Postal Code:

Phone numbers:
Home: Business: Cell:

Email: ____

Yes ☐ No ☐ I consent to receive health and wellness news and information from Lifemark. (You may unsubscribe at anytime).

Appointment Reminder preferences: ☐ Email ☐ Text ☐ Both

Date of Birth / / (Day Month Year) Sex/Gender as indicated on Insurance ☐ F ☐ M ☐ X

Gender Pronouns: ☐ She/Her ☐ He/Him ☐ They/Them ☐ Prefer not to disclose ☐ Other: ______________

Date of Injury (D/M/Y) OR gradual onset ☐ Area of Injury:

Employer/School: Occupation:

Health Card #: ______________________ Version code (ON): ________ Province: __________

For ON/AB: Are you on a Provincially-funded Support Program or qualify as low income? Yes ☐ No ☐
If Yes, please provide name of program, case worker name and phone number:

Extended Health Care Insurance Coverage: ☐ Yes ☐ No For direct billing, please complete below:

Primary Company Name:	Secondary Company Name: (for ON, AB MVA only)
Policy/Plan No:	Policy/Plan No:
Certificate/ID No:	Certificate/ID No:
Policy holder name:	Policy holder name:
Policy holder date of birth (D/M/Y):	Policy holder date of birth (D/M/Y):

Is your injury funded by: ☐ MVA ☐ WCB/WSIB/CNESST ☐ LTD ☐ RCMP ☐ DND ☐ DVA

Claim Number or Member ID: Policy No:
Policy holder Name: Insurance Co. Name:

Employer Name at time of injury: Employer contact & Phone No:

Adjustor/Case Workers' Name: Adjustor Phone No:

For ON/AB/NS MVA claims: Have you completed your Accident benefits package?
(OCF-1/AB1/NS1) Yes ☐ No ☐

Who can we thank for your referral?

Name: Address:

What most influenced your decision to choose Ace Physique?

☐ Family Doctor	☐ Returning Patient/Self	☐ Radio/TV	☐ Trade show/Health Fair
☐ Medical Specialist	☐ Rehab Consultant	☐ Signage/Location	☐ Internal referral
☐ Walk-in Clinic	☐ Google Ads	☐ Social Media	☐ Other (Specify): ____________
☐ Employer	☐ Google listing/Review	☐ Lawyer	
☐ Insurance Co.	☐ Internet/Search Engine	☐ Government	
☐ WCB /WSIB/CNESST	☐ Coach/Teacher	☐ Healthcare Professional	
☐ Friend/Relative	☐ Print Advertising	☐ Blue Nose Marathon	

Photo ID verified: Y/N **HC Expiry:__________** **Staff Initials:__________** **Date:____________**

Patient Intake Form

Physicians	
Family Physician:	Phone:
Referring Physician: ☐ Same as Family Physician	Phone:
☐ Emergency Contact AND/OR ☐ Guardian (for Patients under the age of 18)	
Name:	
Relationship to Patient:	Phone:

Payment Information

I understand that payment for services received at the clinic is my responsibility. If my treatment services are to be submitted directly to an outside agency for payment, and for some reason the third-party payer, such as WCB/WSIB, insurance or employer, denies the claim and/or refuses to pay all or any of the full amount billed, I am responsible for paying the amount outstanding.

I acknowledge if appropriate cancellation notice is not provided I may be charged a cancellation fee up to the full cost of the appointment. I also acknowledge that third party funders may not pay for cancellation charges, and that I will be personally responsible for applicable fees.

____ ____________________

Signed (If the patient is under the age of 18, a guardian must sign for them) Date

____ ____________________

Witness Date

EXTENDED HEALTH CARE (EHC) DIRECT BILLING

We are pleased to offer direct billing if permitted by your extended health care insurance company (EHC). To direct bill your EHC, we require a valid credit card to be added to your file. Direct billing to your EHC on your behalf may be mandatory if your treatment is funded through a motor vehicle insurer or disability claim. Your credit card will only be charged for any balances not paid by your EHC or if payment is issued to you or the plan member instead of the clinic. **Check here for this option** ☐

EXPRESS CHECKOUT SERVICE

For your convenience, and for patients without EHC, we can bill your credit card to facilitate the payment process. This way you avoid standing in line at reception to settle your account after each treatment. Invoices will be prepared for you when payment is processed. **Check here for this option** ☐ Billing frequency preference: daily / weekly (circle)

For security purposes, your credit card information will be completely removed from our records upon your Discharge.

Please sign below as consent to retain and store your credit card credentials, for the billing purposes contemplated by this agreement.

Name on Card: ____________________________________

Signature: ______________________________________ Date: __________________

Witness: _______________________________________ Date: ___________________