REJUVENATION
HEALTH SERVICES

CLIENT INTAKE SHEET

NAME: ____M / F   DATE OF BIRTH: ______ M ______D _______Y

ADDRESS: ____ POSTAL CODE:______________________

PHONE: (H) ___________________________ (W) _________________________ (C)__________________________

FAMILY DOCTOR: ____ AHC NUMBER: _______________________

EMERG CONTACT:_____________________________ PHONE:__________________ RELATION: _______________

REFFERED BY: _____________________________ EMAIL ADDRESS: _____________________________________

Can we email you appointment reminders? Y / N
Can we add you to our email list to receive health tips, health information, and any special offers we may have? Y / N

FOR MVA CLIENTS

INSURANCE COMPANY: ____ PAPERWORK COMPLETED: Y / N

ADJUSTER NAME: _____________________________ PHONE: _____________________ FAX: __________________

CLAIM NUMBER: ___________________________________ DATE OF ACCIDENT: ______________________________

FOR WCB CLIENTS

EMPLOYER NAME: ____ PHONE NUMBER: ____________________

JOB TITLE: ____ CURRENTLY WORKING: Y / N

ADJUSTER NAME: ______________________________ PHONE: ____________________ FAX: __________________

CLAIM NUMBER: ____ DATE OF ACCIDENT: _________________________

BILLING PROCEDURES

Payment will be required after each session. We are able to bill directly for recent car accidents, WCB incidents, and most major insurance benefit carriers, however **we cannot verify your daily or annual limits. It is your responsibility to check** this with your employee handbook or employer. If we are unable to bill your insurance company directly we will provide you with all appropriate invoices and receipts necessary for reimbursement. **PLEASE NOTE THAT WE ARE UNABLE TO BILL DIRECTLY FOR REFLEXOLOGY, PSYCHOLOGY, AND ACUPUNCTURE.** PLEASE INITIAL ______

ATTENTION MVA AND WCB CLIENTS

If you neglect to provide us with the accurate billing information, you will be responsible for all monies owing regarding your treatment. Your invoices will be submitted to you for payment before any further appointments can be scheduled.
PLEASE INITIAL ______

ATTENTION ALL CLIENTS

Please make every effort to attend each scheduled appointment on time. If you are **unable to keep an appointment**, please make sure to notify the clinic **24-hours in advance** where possible. If you do not provide this notice, a **"Did Not Attend" fee in the amount of the full appointment fee** will be charged to your account. PLEASE INITIAL ______

I have reviewed the Clinic Orientation booklet and understand its contents. Whatever I did not understand has been satisfactorily clarified by a staff member.

SIGNED: ____ DATE: ________________________