**INSURANCE FORMS**

**\*\* Manitoba Health does not fund physiotherapy sessions in a Private Practice Clinic**

**PERSONAL INFORMATION:**

**NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_D.O.B\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Last First Month/Day/Year**

**PRIVATE INSURANCE**

**Blue Cross Great West Life Sun Life**

**Group/ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contract/Plan #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**For Staff Only:**

**Coverage: \_\_\_\_\_\_\_\_%, Maximum \_\_\_\_\_\_\_\_\_\_\_\_/year, Deductible \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Renewal month: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Doctor’s Referral Required**

**Separate Acupuncture for Blue Cross: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**WORKERS COMENSATION BOARD (WCB) MANITOBA PUBLIC INSURANCE (MPI)**

**Claim #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Injury/Accident Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Case Manager: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I WILL BE SUBMITTING MY OWN CLAIMS / I DO NOT HAVE INSURANCE**

**I understand that in the event my 3rd Party Insurance (including WCB and MPI) does not provide coverage for my physiotherapy sessions, I will be held financially responsible.**

**CANCELLATION POLICY: For patients who have rescheduled, cancelled or missed 2 or more appointments, we have the following policy:**

**Cancellations with less than 24 hours notice: $25 Missed Appointments: Full treatment fee**

**I understand that I am responsible for all cancellation and missed appointment fees, not my 3rd party insurance company.**

**Physiotherapy Assessment: $69 With Acupuncture: $85**

**Physiotherapy Treatment: $55.50 With Acupuncture: $71.95**

**Neurological Vestibular Physiotherapy Assessment: $125 Subsequent Treatments: $90**

**I HEREBY AGREE TO THE TERMS ABOVE**

**DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SIGNATURE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**