The Ability Clinic
Bone • Muscle • Nerve

New Patient Form

Thank you for choosing The Ability Clinic. Please fill out this form to ensure that you receive the appropriate care. All information is Private and Confidential.

Personal Information

Legal Name:

Preferred Name (*if different from above*):

Date of Birth (*DD/MM/YYYY*):

Gender Identity: Male Female Other

Street Address:

City: **Province**: **Postal Code**:

Phone: Mobile Home/Work

Emergency Contact Name: **Phone**:

Family Physician Information

Name:

Phone: **Fax**:

Address:

Cancellation Fees

- I understand that at the time of booking, credit card information will be held to secure an appointment.
- Should an appointment be cancelled within 24 hours, or if the appointment time is not honoured, a $50-100 fee will be applied.
- We understand that exceptional circumstances may arise, through no fault of your own, but this policy will apply to all patients who confirm an appointment time.
- The main purpose of this policy is to act as an instrument of fairness, to the public health care system, our clinic, and to all our other patients. We hope to rarely apply it.

Patient Signature: **Date** :

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Email Communication

- I wish to use email as one of the ways in which to receive communication with clinicians/staff associated with The Ability Clinic
- I understand the risks associated with communication by email, and I hereby waive, release, and discharge from all liability, The Ability Clinic, its employees, and all physicians connected in any way with me as a patient, for any complication which may arise from the use of email.

Email Address:

Patient Signature: **Date**:

Consent

- The Ability Clinic has a Privacy Policy about the collection, storage, use and disclosure of personal information and about the protection of personal information. You have the right to review your personal information, and the Privacy Policy is available to you upon request.
- I have read and understand this information, and give consent to The Ability Clinic to:

1. Proceed with assessment and treatment
2. Collect, store, and dispose of my personal information according to the Privacy Policy
3. Share my information with the following:

Family Physician:	Yes	No
Specialist:	Yes	No

Other:

Patient Signature: **Date**: