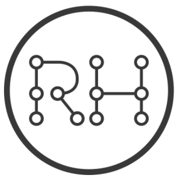

Redefined ◦ Health

PATIENT INFORMATION

Name: ____Date:___________________

Weight: _______ Height: ________ ☐ Female ☐ Male Age: _________Birth Date (dd/mm/yr):______________

Address: ________________________________City: ___________________ Postal Code: _________________

Home Ph: _____________________Cell Ph: ________________________ Work Ph: _______________________

Occupation: ____

Email: ____

Your email will only be used for appointment reminders and any other appointment related correspondence. It will not be given to any third party for any reason.

☐ Check this box to sign up for our monthly newsletter.

AHC #: ____

**please be advised that personal health care numbers are collected in accordance with the Alberta Health Act. Numbers are protected and used solely for the purposes of diagnosis, treatment and referral. Alberta Health Care currently does not make payments for any portion of treatment offered at Redefined Health.*

Emergency Contact Name: ____________________________________ Phone #: ____________________

Parent Contact (if patient is <18 years of age): ____

How did you hear about the clinic?

☐ Website ☐ Google ☐ Yelp ☐ Event/Race

☐ Person: ________________________________ ☐ Other Search Engine: _________________________

☐ Street Sign ☐ Previous Patient of Provider ☐ Other

We appreciate at least **24 hours'** notice for cancellation of any appointment. If circumstances are such that an appointment must be missed, please notify us as soon as possible. **Please be advised that no-show appointments will be subject to a fee of 50% of the appointment value.** Redefined health does offer direct billing to secondary insurance companies on your behalf. However, it is the responsibility of the patient to confirm and understand the extent of their coverage amounts and restrictions with their individual insurance company. All service payments are due when service is rendered. For any amounts not immediately covered by extended health benefits, payment is accepted in the form of Cash, Debit, Visa or MasterCard. I understand that I am responsible for payment of all services or treatments rendered at Redefined Health.

Patient Signature: ____ Date: _______________________