Jag Grewal, RMT

IMPULSE HEALTH AND WELLNESS

#101-15399 102A Avenue
Surrey, B.C. V3R 7K1
Tel: (604) 951-8959

Personal information:

Name: _____ Gender: _____
Address: _____ City: _____ Province: _____ Postal code: _____
Birth date: month _____ day _____ year _____ Age: _____ Height: _____ Weight: _____
Home phone: _____ Alternate phone: _____
Email address: _____ Email Reminder ☐ No ☐ Yes
Emergency contact name : _____ Emergency contact phone: _____

Medical doctor:

Name of medical doctor: _____ Phone number: _____
Location: _____

Employment information:

Occupation: _____ Employer: _____
Employer Address: _____ Phone: _____

Medical insurance:

Personal Health No/Care Card.: _____
Do you have extended health care that covers Massage Therapy? ☐ No ☐ Yes.

How did you know about this clinic?

☐ Friend or Patient from this office (name) _____ ☐ Yellow Pages
☐ Other health care professional (name) _____ ☐ Sign
☐ Other (specify) _____ ☐ Web Site

Personal health information:

Women only: Is it possible that you may be pregnant? ☐ No ☐ Yes. The expected due date is: _____
Please list all previous illnesses, surgeries, accidents, injuries allergies and other significant health conditions:

_____
_____
_____

Have you ever been diagnosed with Hepatitis? ☐ No ☐ Yes.
Have you ever been tested for HIV? ☐ No. ☐ Yes. Test date: _____ Test result: ☐ Positive ☐ Negative.

Are you presently on any medication? ☐ No ☐ Yes. Please list: _____
_____
Have you received Massage Therapy before? ☐ No ☐ Yes. Date of last visit: _____
Do you have an open ICBC/WCB claim? ☐ No ☐ Yes

(please turn page over)

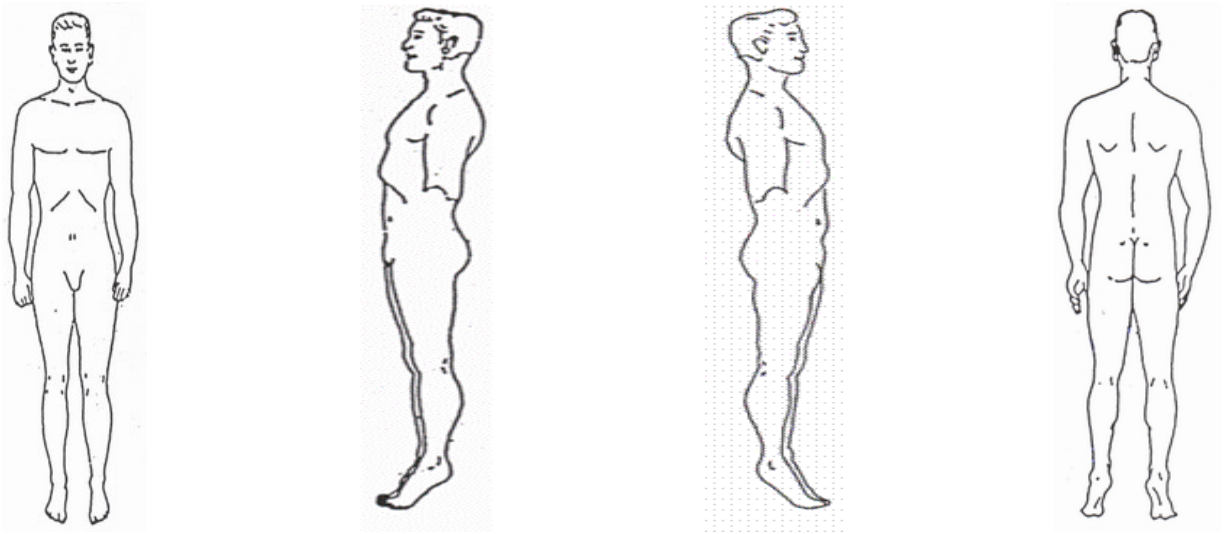
· Reason for visit (major complaint): _____

_____

· How did your symptoms occur? _____

· When did your symptoms start? _____

· Please indicate (circle) on the diagram below the area(s) in which you are experiencing problems:



Fee Schedule: (*Subject to change without notice)

$75.00	half hour massage therapy
$120.00	one hour massage therapy

48 hours notice is required for cancellation or rescheduling of an appointment. I understand that if such notice is not given, I will be billed for the FULL FEE* of the missed visit.

Extended Health Care Insurance plans will often cover massage therapy. Please check your plan to determine your coverage. If you are eligible for coverage, it is the **patient's responsibility to submit their receipt of service to their health insurance provider for reimbursement.**

I, the undersigned, also understand that Jag Grewal,RMT is independent and separate practice from Impulse Health And Wellness.

Please be advised that your treatment time, will/may consist of an evaluation, hands on massage, hydrotherapy, stretching and/or rehab. (As seen necessary by your Registered Massage Therapist.)
If you are late for your scheduled appointment, you will receive treatment for only the remaining time of your appointment.

Patient's Signature: _____ **Date:** _____

(or signature of guardian or spouse authorizing care)

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Agreement of Service

Navpreet Muker-Lehal, R.M.T.
Jag Grewal, R.M.T

I, the undersigned, understand that a limited number of massage treatments are covered by the B.C. Medical Plan and that services rendered in this office are the responsibility of myself, should Medical Service Plan fail to pay for all or part of the amount due.

Extended Health Care Insurance often covers massage therapy. Please check your plan to determine your coverage. If you are eligible for coverage, it is the **patient's responsibility to submit their receipt of service to their health insurance provider for reimbursement.**

48 hours notice is required for cancellation or rescheduling of any appointment. I understand that if such notice is not given, I will be billed for the FULL FEE of the appointment. _____ Patient's Initial

If you are late for your scheduled appointment, you will receive treatment for only the remaining time of your appointment.

I also understand that the email for my scheduled appointments are a courtesy, and may or may not be provided during the course of my treatment.

Please be advised that your treatment time will/may consist of an evaluation, hands on massage, hydrotherapy, stretching and/or rehab. (As seen necessary by your Registered Massage Therapist.)

I understand that Navpreet Muker-Lehal, RMT and Jag Grewal, RMT
are independent and a separate practice from Impulse Health And Wellness.

Patient's Signature: _____ Date: _____
(Or signature of guardian or spouse authorizing care)

INFORMED CONSENT TO MASSAGE THERAPY AND CARE

I hereby request and consent to the performance of massage treatments and other procedures, including various modes of physical therapy on me by the massage therapist named below and/or anyone working in this clinic authorized by the massage therapist named below.

I have had an opportunity to discuss with the massage therapist named below and/or other office or clinic personnel, the nature and purpose of massage treatments and other procedures. I understand that the results are not guaranteed.

I further understand and am informed that, as in all health care, in the practice of massage t herapy there may be some slight risk(s) to treatments. I do not expect the therapist to be able to anticipate and explain all the risks and complications and I wish to rely on the therapist to exercise judgment during the course of the procedure which the therapist feels at the time, based upon the facts then known, and is in my best interests.

I have read the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above mentioned massage therapy p rocedures. I intend this consent form to cover the entire course of treatment for my present and future conditions.

TO BE COMPLETED BY PATIENT:

_____ _____

PRINT PATIENT NAME **SIGNATURE OF PATIENT (or parent/guardian)**

_____

DATE SIGNED

FOR OFFICE USE ONLY

Navpreet Muker-Lehal, RMT
Jag Grewal, RMT