New Leaf Total Wellness, B-2309 McCallum Road, Abbotsford, V2S 3N7

New Patient Intake

Please complete the following information to help us serve you best. All information is confidential and remains property of New Leaf Wellness Centre. Thank you!

First Name: _____ Last Name: _____

Preferred Name: _____

Email: _____

Home Phone: _____ Mobile Phone: _____

Street Address: _____ Suite Number: _____

City: _____ Prov: _____ P.C. _____

DOB: _____ PHN: _____

Family Doctor: _____ Phone: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: _____

Gender: ☐ Male ☐ Female ☐ Prefer Not to Say

Occupation: _____ Employer: _____

If under 18: Guardian Name: _____

New Leaf Reminders: *Please let us know how you would like to be updated and reminded of appointments*

☐ Email 2 days before appointment

☐ Text Message 2 days before appointment

☐ Phone call 24 hours before appointment

***You will receive email notifications of all NEW, CANCELLED AND RESCHEDULED appointments*

How did you hear about us? _____

☐ By checking this box, you are opting out of New Leaf Wellness Centre's marketing emails which consist of clinic updates, news and special offers.

Privacy and Sharing of Information

I authorize the clinic and its associated health professionals to collect my personal and medical information. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission. I also consent for my treatment and health information to be shared amongst the health care practitioners at this clinic.

Initial _____

Credit Card on File and Payment Policy

To best serve you and to minimize accounts being placed on hold, we require an up to date and valid credit card on file. This credit card is only used in the event that your third party payee denies or rejects any claims and incidentals whereby a private payment was mistakenly missed.

Initial _____

Cancellation Policy

Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in the therapists' day that could have been filled by another patient. As such, we require 24 hours notice for any cancellations or changes to your appointment. Patients who provide less than 24 hours notice, or miss their appointment, will be charged a cancellation fee.

I agree that my credit card on file will be processed for late cancellations or missed appointment.

Initial _____

Name: _____

Signature: _____

Date: _____