ESSENTIAL COMPRESSIONS
(within)

Perfect Balance
Wellness Centre

CLIENT INFORMATION

125 Bedford Road • Kitchener, ON N2G 3A3

It is the patient's responsibility to ensure they are eligible for benefits at the time their order is placed.
No Returns or Exchanges on Compression Garments.
Official receipt for submission to insurance company will be given.

Client Information (please print clearly)

Name: _____ Date of Birth: (mm/dd/yyyy) ____/____/_____ Age: _____

Address: _____ City: _____ Postal Code: _____

Phone: (H) _____ (B) _____ (Cell) _____

Email: _____

➪ Referring Physician: _____ Prescribed: ❑ Yes ❑ No

Client Consent Statement

In keeping with the Health Care Consent Act (1996), it is my choice to receive therapy. I understand that an assessment by a therapist is required to determine the best course of treatment. I am aware that all information provided is private and confidential and will not be released without my written consent. I agree to communicate with my therapist at any time if I have any questions, if I feel uncomfortable, or I feel that my well being is being compromised. I will consent to the therapist working only on those areas of my body that I am comfortable with. I am aware that I may remove only the clothing with which I am comfortable and may terminate the treatment at any time at my discretion. I am aware that the clinic is not responsible for any lost, stolen or damaged articles.

Signature : _____

Date: _____