Cassandra Clinic
Registration Form

Health Card Number: _____ Version Code (letters): _____

Last Name: _____First Name: _____ Middle Name: _____ ☐Male ☐Female

Date of Birth: Year_____/Month_____/Day_____

Address: _____ Apt: _____

City: _____ Province: _____ Postal Code: _____

Email address: _____

Phone: (Home) _____ (Work)_____(Cell) _____

Name of Emergency Contact: _____ Phone:_____

Relationship to Patient: _____

Family Doctor's Name: _____ Phone: _____

Insurance Information:

I authorize Cassandra Clinic Inc. to furnish information to insurance carriers concerning my care. I agree that for any services not covered by OHIP to pay Cassandra Clinic Inc. for services rendered to my dependants or myself. I understand that I am responsible for any amount not covered by OHIP. Any balance is ultimately my responsibility and in the event my balance is transferred to a collection agency or attempts are made to collect a delinquent balance using an outside source, I will be responsible for collection costs, attorney fees, and /or court cost up to and beyond the existing balance incurred.

Consent to Treat & Medical Records Release Authorization:

I authorize Cassandra Clinic Inc. providers to provide treatment that they may deem advisable for my dependants and me. I understand that these services are voluntary and I have the right to refuse these services. In the event of a life-threatening emergency, I consent for the provider to administer emergency treatment.
I authorize Cassandra Clinic Inc. to obtain any previous medical records, for my dependants or myself, including lab and imaging results, if my providers feel it is necessary for the care of my dependants or me.

I have read the above items regarding OHIP and financial responsibility, consent and medical records and agree to the terms and conditions related to each item.

_____ _____

Signature of Patient or Responsible Party **Date**

Please present your Ontario Health Card at the Reception Desk