

Physics CPM PATIENT AGREEMENT FORM  Patient Information  Plast Name: *First Name:   *First Name:   *First Name   *		The Physio Store Inc.		
Physis C.			22635 Kon	noka Road, Komoka, Ontario
J Store	DM DATIENT ACDEEN	IENT EODM	t: 519-43	9-6333 tf: 1-844-939-6333 siostore.ca
Patient Information	PWI PATIENT AGREEN	IENT FORIVI	,	
*Last Name:	*First Name:	□*N	1alo	*Required Fields  D*Female
*Address:	First Name:		iale	□ Female
*City:	*Province:	*Post	al Code:	
*Home #:	Work #:	Cell		
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*CPM Type:	<u> </u>	☐ Hand	Ankle	Other:
Ordering Physician/Therapist	lee 🗀 Silouldei 🗀 Wrist	<b>—</b> папи	LI Alikie	□ Otilei.
*Ordering Physician:	Phone #:	*Hosp	ital·	
Therapist:	Phone #:	1103	, itali	
Diagnosis:		Proc	edure:	
Protocol Information (Office Use)				
Beginning ROM:	Fre	quency Hours/Day:		
Other Instructions:				
☐ Left ☐ Right ☐ Bilateral	☐ Per Signed Physician Protocols ☐ F	atients specific per Ph	ysician Orde	ers 🔲 Pre-Op Setup
Equipment Rentals (Office Use)				
Model:	Serial #:			
Estimated # of Rental Days:	☐ 14 days ☐ 21 days	□ 30 days	☐ Oth	ner
*Payment Information				
I authorize The Physio Store Inc. to utilize understand that I will be notified by phon	my credit card information for any unpaid ne of all charges prior to the use of my cred		charges. I	Initials:
☐ Visa VISA ☐ MasterCard	Credit Card #:		Expiry [	Date:
Cardholder Name:	Cardholder Phone #:		Billing F	Postal Code:
☐ Cheque Chequ	ue Amount:			CVC:
Patient Waiver				
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