WCB INTAKE FORM

NAME: _____

(Please Print)

WORK PLACE INJURY

Have you reported your injuries to YOUR WCB ? ❑ **Yes** ❑ **No**

Have you filed out an incident report at your place of employment? _____

Date of Accident: _____

Employer Name: _____ Job Title / Occupation: _____

Employer Address: _____ Postal Code: _____

Supervisor / Contact Name:_____ Phone Number: _____

Are you currently working? ❑ Yes ❑ No Do you have a job to return to? ❑ Yes ❑ No

WCB

Adjuster Name: _____ Phone Number: _____

WCB Claim Number: _____

Do you have legal representative? _____

TREATMENT REQUIREMENTS

After your **initial assessment**, your therapist will submit a report to your **adjuster** outlining the number of treatments **prescribed specifically for our clinic** that follows the WCB Protocols.

Please note:

- The treatment plan & number of sessions approved are **valid for services provided by therapists at Lime Health**.
- If you choose to seek care at **another clinic**, their practitioners will be required to complete their **own assessment** and submit a separate treatment plan for approval.
- **Treatment counts do not transfer** between clinics. The sessions prescribed at our clinic cannot be shared or split with other clinics.

CANCELLATION & NO SHOW

To ensure fairness and improve access to appointments, a strict cancellation policy is now in place. We value your time and appreciate your understanding in respecting ours.

Same-day cancellations or no-shows will be charged **100% of the scheduled service fee**.
Cancellations made the day before your appointment, including messages received after hours or on Sundays, will incur a **$50 charge**.

These charges apply to **every occurrence**, regardless of the reason.

The above information is true to the best of my knowledge.

_____ _____

Patient Printed Name Patient Signature Date_____