New Patient Package

Intake Form · Informed Consent · Clinic Policies

iCollab Healthcare — Surrey, BC

Welcome to iCollab Healthcare. Please complete this package in full and bring it with you to your clinic, or complete it online. Each family member requires their own form. If a section does not apply to you, please write “None” so we know it was not missed.

PART 1

New Patient Intake Form

Tell us about you so we can set up your care

PATIENT INFORMATION

Given Name: ____________________ Last Name: ____________________

Personal Health Number (PHN#): ____________________

Gender: ____________________ Age: ____________________

Date of Birth: ____________________

CONTACT INFORMATION

Home Address: ____________________

Mobile Phone Number: ____________________ E-Mail Address: ____________________

Emergency Name and Number: ____________________

OCCUPATION

Occupation: ____________________ Work Phone: ____________________

REFERRAL INFORMATION

Who referred you to us: ____________________

Where did you hear about us: ____________________

FAMILY MEMBERS

Other family members joining at the same time? (each needs their own intake form)

____

____

CURRENT FAMILY PHYSICIAN

Your current family physician MUST be disclosed as we will request your current records. If you have no current physician, please write down your LAST family physician so we can request your old records.

Physician's Name: ______________________

Clinic Name and Address: ______________________

Phone and Fax Number: ______________________

MEDICAL HISTORY

Current Medical Conditions

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________

Family History (relation, condition, year)

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________

Past Medical Conditions

1. ______________________
2. ______________________
3. ______________________
4. ______________________

Social History (per week/month/year)

1. ______________________
2. ______________________
3. ______________________
4. ______________________

Social history includes: Alcohol use · Nicotine use · Cannabis use · Drug use (e.g. opioids, cocaine, etc.)

SURGICAL HISTORY AND YEAR

____

____

____

ALLERGIES (AND WHAT HAPPENS?)

Medications: ______________________

Food Allergies: ______________________

CURRENT MEDICATIONS AND DOSE

____

____

INSURANCE / LEGAL CLAIMS

Any current ICBC, WSBC, or Medical-Legal claims ongoing? ______________________

PART 2

Informed Consent & Clinic Policies

Please read carefully before signing

I. Introduction

This Informed Consent Agreement (the "Agreement") is entered into between the patient ("Patient" or "You") and iCollab Healthcare (the "Clinic"). The purpose of this Agreement is to provide You with information about the Clinic's policies, procedures, and services, and to obtain Your informed consent for the treatment You will receive at the Clinic.

II. Services Offered

The Clinic offers medical and health care services, including but not limited to diagnostic assessments, medical treatments, and health management services. The specific services that You will receive will be discussed with You and documented in Your medical record.

III. Risks and Benefits

You acknowledge that any medical treatment has inherent risks, and that no guarantee can be made as to the outcome of Your treatment. You understand that the benefits of the treatment may not be immediately apparent and that the results may vary. You also understand that there may be alternative treatments available, and that You may choose to undergo such treatments instead.

IV. Confidentiality

You acknowledge that the Clinic will maintain the confidentiality of Your medical information in accordance with applicable laws and regulations. You understand that the Clinic may release Your medical information to third parties as necessary for the provision of medical treatment or for billing purposes, and that You may have the right to access Your medical information. You consent to allow communications through electronic means for personal health services and information and understand there may be inherent risks of using this form of communication as per CMPA guidelines (including but not limited to phone appointments, emails and text messages).

V. Use of Artificial Intelligence (AI)

You acknowledge and consent that Your physician and the Clinic may use artificial intelligence (AI) tools to assist with Your care — for example, to help with clinical scribing and documentation, drafting and scripting, administrative tasks, and other measures that improve the efficiency and quality of care. Any such tools are used to support, not replace, the clinical judgement of Your physician, and Your information continues to be handled in accordance with applicable privacy laws.

VI. Payment

You understand that services rendered at the Clinic may be covered by the Medical Services Plan of British Columbia ("MSP"). Any charges not covered by MSP will be Your responsibility. You agree to pay all charges for services rendered, including any co-payments, deductibles, or charges for services not covered by MSP.

VII. Acknowledgment of Understanding

You acknowledge that You have read this Agreement, that You understand its contents, and that You agree to be bound by its terms. You acknowledge that You have had the opportunity to ask questions and that Your questions have been answered to Your satisfaction. You agree to release, indemnify, and hold/save harmless the Clinic, its Physicians, its officers, directors, employees, agents, and representatives from any and all liability, claims, demands, actions, or causes of action, whether at law or in equity, arising from or in connection with the Clinic and/or your consultation and/or treatment regardless of whether they result from the actions, negligence, or omissions of the Physicians, the Clinic, or any third parties.

VIII. Revocation of Consent

You understand that You have the right to revoke Your consent to treatment at any time, and that such revocation will not affect the legality of any actions taken prior to the revocation.

IX. Dispute Resolution

In the event of a dispute between You and the Clinic, You agree to first attempt to resolve the dispute through good faith negotiations.

X. Governing Law

This Agreement shall be governed by and construed in accordance with the laws of the Province of British Columbia and the laws of Canada applicable therein.

XI. Disrespectful or Abusive Language and/or Behaviour

Any disrespectful or abusive language or behaviour directed towards staff by You will not be tolerated and You may be discharged from the Clinic. The Clinic has a ZERO tolerance policy and You will no longer be allowed in the Clinic.

Acknowledgement & Signature

By signing, I agree to be bound by all clinic policies and the Informed Consent above.

Patient Name: ______________________ Date: ______________

Signature: ____