

MICHAEL MULVEY, MD, FRCPC
Adult Psychiatry & Psychotherapy

New Patient Intake Form

Date: _____

Name: _____
LAST FIRST

Date of Birth: ____/____/____
M D Y

Address: _____

CITY POSTAL CODE

Telephone: _____
PREFERRED CONTACT NUMBER

ALTERNATE

Email: _____

B.C. CareCard Number: _____

Fees for Services:

Most services provided by Dr. Mulvey are fully insured by the provincial health care plan. You must have a valid B.C. CareCard and personal health number in order to receive service. Certain requests for information by third parties (insurance companies, lawyers, employers) will result in a fee, for which you may be responsible. Dr. Mulvey will provide an estimated fee prior to completing these third party services. A signed "informed consent" form will also be required in order to release any medical information.

Cancellation Policy:

If you are unable to attend an appointment, you are required to provide at least 24 hours notice. If you miss an appointment, or fail to provide 24 hours notice, you are responsible for the **fee of \$40**. The fee must be paid in full to the front desk within 7 days of your missed appointment.

By signing this form I attest that I have read and agree to the above information.

Signature