PATIENT INTAKE FORM

DUSK PHYSIOTHERAPY

Name: _____ M ☐ / F ☐ Date of Birth: _m__/_d__/__y__

Address: _____ Apt.____ City: _____ Postal Code: ____-____

Home: (____)_____- _____ Work: (____) _____- _____ Cell: (____) _____- _____

Email Address: _____ Do you want to be updated via Email? Yes ☐ No ☐

Occupation: _____ Employer _____

Family Physician: Dr. _____ Permission to Consult? Yes ☐ No ☐ Initial: ____

Physicians Phone No. (____) _____-_____ Address: _____

Main Interest For Today's Visit? Chiropractic ☐ Physiotherapy ☐ Massage ☐ Orthotics/Shoes ☐ Other _____

Major Area(s) of Complaint/Pain? 1)_____2) _____3)_____

Therapy Goals: Pain Relief ☐ Flexibility ☐ Core Strength/Endurance ☐ Improved Posture ☐ Weight Loss ☐ Maintenance ☐

1)Primary Insurance Company: _____ Group/Policy/Employee ID_____

Policy Holder? Self ☐ Spouse ☐ Other ☐ _____ Name: _____ DOB: _m__/_d__/__y__

2)Secondary Insurance Company _____ Group/Policy/Employee ID:_____

Policy Holder? Self ☐ Spouse ☐ Other☐ _____ Name:_____ DOB: _m__/_d__/__y__

Auto Accident Information

Insurance Company: _____

Claim No. _____Accident Date _m__/_d__/__y__

Adjustor Name: _____ (P) _____

(F) _____

WSIB Information

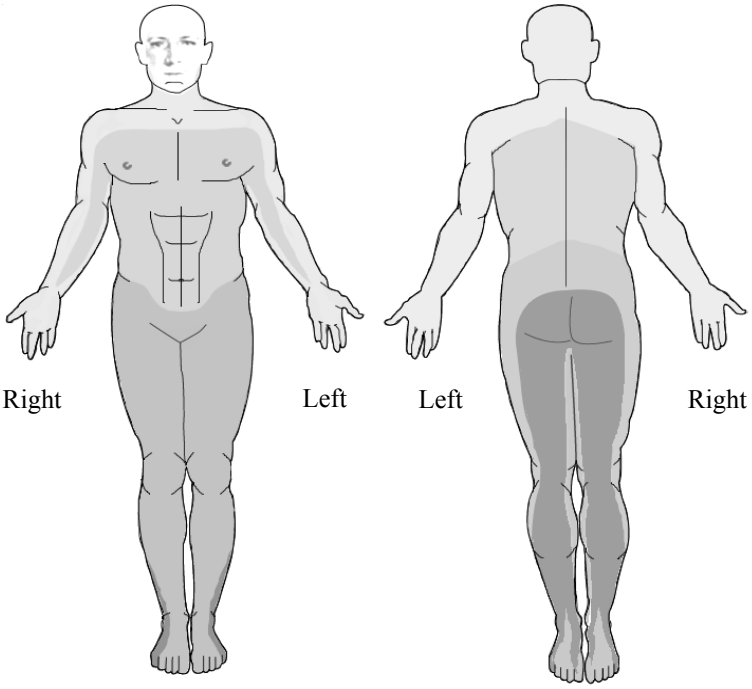
Is This a New Injury Claim? Yes ☐ No ☐

Claim No. _____Accident Date _m__/_d__/__y__

Adjudicator Name: _____ (P) _____

(F) _____

In the Diagram provided mark the areas on your body that you feel best represents the pain(s) or sensation(s) you are **currently** experiencing. Please include all areas. Use the symbols provided below.



0 ——————————————— **10**

Place a vertical mark along the line to indicate your current level of pain.
(0 being the least pain and 10 being the worst pain)

Symbols:

Tight and Stiff	/ / /
Sharp	II II II
Dull Ache	+++
Burning	X X X
Numbness	===
Pins & Needles	●●●
Shooting Pain	^ ^ ^

Please check the following health conditions that you apply to <u>you</u>, both past and present.

- ☐ Abdominal Pain
- ☐ Cancer
- ☐ Chronic Pain
- ☐ Diabetes
- ☐ Fatigue/Weakness
- ☐ Fracture
- ☐ Headache/Migraine
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Joint Pain/Stiffness
- ☐ Kidney Problems
- ☐ Low Back Pain
- ☐ Muscle Cramps/Spasm
- ☐ Neck Pain/Stiffness
- ☐ Numbness/Tingling
- ☐ Osteoporosis
- ☐ Poor Circulation/Bruising
- ☐ Rheumatoid Arthritis
- ☐ Scoliosis
- ☐ Sciatica
- ☐ Spinal Cord Injury
- ☐ Sprain / Strain
- ☐ Stroke/Aneurysm
- ☐ Thyroid Disease
- ☐ Other_____

Please check the following health conditions that you apply to your <u>immediate family</u>, both past and present.

- ☐ Cancer _____
- ☐ Diabetes _____
- ☐ Stroke/Aneurysm _____
- ☐ Heart Disease _____
- ☐ Cholesterol _____
- ☐ High Blood Press. _____
- ☐ Other: _____

Clinic Policy

DUSK PHYSIOTHERAPY maintains a standard clinic policy designed to maintain a fair and professional relationship toward all our patients in order to provide the most efficient and effective care possible. As a patient we require you to provide accurate and honest information as it relates to your personal and medical health history and that you be considerate to the doctors, therapists, administration staff and fellow patients while attending our facility.

Initial: _____

Information/Record Keeping Policy

DUSK PHYSIOTHERAPY requires a certain amount of information as it relates to your current condition and relevant health history in order to provide you with the most appropriate and efficient care possible. DUSK PHYSIOTHERAPY is responsible for the privacy of all our patients and all information provided will be kept strictly confidential.

Initial: _____

Cancellation Policy

DUSK PHYSIOTHERAPY enforces a strict cancellation policy to ensure a sufficient amount of time for each patient to receive the care they need on any given day. Therefore, DUSK PHYSIOTHERAPY requires a 12 hour notice for cancellation of any appointment. A fee of **$30.00** will be charge for missed appointments without a 12 hour notification. This fee is not covered by insurance plans and thus must be paid at the clients own expense.

Initial: _____

Financial Policy

All services rendered are to be paid for at the time of service. All services provided are covered by most Extended Health Care plans and all patients will be provided with the appropriate invoices for submission to their respective insurance company, unless otherwise specified.

Initial: _____

Treatment Liability Waver

Doctors of chiropractic, Physiotherapists and Massage Therapist who use manual therapy techniques are required to advise patients that there are or may be some risks associated with such treatment. I understand and am informed that, as in the practice of medicine, there are some risks to treatment including, but not limited to the following:. Some patients may experience **short term aggravation of symptoms, rib fractures, muscle and ligament strains or sprains, bruising or disc herniations**, as a result of manual therapy techniques. While extremely rare, there are reported cases of **stroke** associated with many common neck movements including, chiropractic adjustment of the upper cervical spine. However, present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Chiropractic treatment has been demonstrated to be an effective treatment for many neck & back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. The risk of injuries or complications from chiropractic treatment and/or manual therapy is substantially lower than that associated with many medical or other manual treatments, medications and procedures given for the same symptoms.

Initial: _____

Exercise Liability Waver

The client expressively acknowledges that he/she may be engaging in physical exercise while attending the clinic's facilities, which could cause injury to the client. The client hereby states that he/she is and will be voluntarily participating in these activities and the client hereby assumes all risk of injury which might result from these activities. The client hereby waives and releases any and all claims that he/she now has or many have against the clinic, its employees or agents for injury sustained by the clinic as a result of these physical exercises and activities. The client hereby acknowledges that he/she has carefully read this waiver and release and thus fully understands that it is a release of liability of the clinic and agrees that such a waiver and release is reasonable and proper based on the nature of services provided by the clinic.

Initial: _____

Policy Agreement and Informed Consent

I have read, understand and agree to the clinic policy's set forth by DUSK PHYSIOTHERAPY. To the best of my knowledge, I certify that the information provided in the above forms is accurate and that I will advise DUSK PHYSIOTHERAPY Staff of any changes pertaining my personal information and relevant health history. I consent to the treatment offered or recommended to me by my health care provider and I intend this consent to apply to all my present and future care.

_____	_____	_____
Patient Signature or Parent/Legal Guardian	Patient Name or Parent/Legal Guardian (Printed)	Date (m/d/y)

Payment Options

☐ Pay As You Go: The patient will pay for services rendered and/or product received by DUSK PHYSIOTHERAPY on a pay per visit basis. Invoices for all services rendered will be provided to the patient who will in turn, be solely responsible for submitting claims to their extended health care provider for reimbursement, unless otherwise specified.

☐ Service Rendered Agreement (SRA): The patient will provide the clinic with credit card information to be kept on file. The patient will be charged any outstanding balances on their account for services rendered and/or product received at the end of each month. Invoices will be processed by DUSK PHYSIOTHERAPY and sent to the patient's extended health care provider for reimbursement.

☐ Assignment of Benefits (AOB): The patient will sign all necessary insurance claim forms allowing the "authorization of payment" from the insurance company directly to DUSK PHYSIOTHERAPY, for all services rendered and/or product received. DUSK PHYSIOTHERAPY will be responsible for submitting all claims to the patient's extended health care provider for reimbursement via mail or online (i.e) Telus Health E-Services.

☐ Motor Vehicle Accident (MVA) / Workplace Safety and Insurance Board (WSIB): The patient will sign all necessary insurance claim forms allowing the "authorization of payment" from the insurance company directly to DUSK PHYSIOTHERAPY for all services rendered and/or product received. DUSK PHYSIOTHERAPY will be responsible for submitting all claims to the patient's MVA Insurance Company or WSIB.

Please Note: Payment policies that incur a deductible or provide partial payment will require the patient's credit card information to be kept on file and subsequently billed for any outstanding balance that for any reason is not covered by their insurance policy or by the patient themselves. While DUSK PHYSIOTHERAPY may record insurance information and help to keep patients informed about their eligibility and coverage limits, it is the still PATIENT who is ultimately responsible for tracking their services, billings and coverage limitations. Credit card information will be kept strictly confidential and will only be charged for any outstanding amounts owied for services or products that have been rendered or provided.

Payment Policy Acknowledgment

I, _____, have read and or have been explained the payment options available to me, including all terms and conditions set out by DUSK PHYSIOTHERAPY and agree to abide by them all times of treatment. I understand that payment is expected in full for all services rendered and/or product ordered and I that I may, at any time, request any or all paid or unpaid invoices to my account. I have agreed to the above mentioned payment option(s) and thus allow DUSK PHYSIOTHERAPY to debit my credit card for any outstanding balances that have been incurred on my account as set out in this policy.

_____ _____ _____

Credit Card Number *Type* *Expiry Date*

_____ _____

Patient Signature *Date*