PATIENT INTAKE FORM

DUSK PHYSIOTHERAPY

Name: _____ M ☐ F ☐ Date of Birth: m / d / yy

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

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

Email Address: _____ Do you wish to receive appointment reminders 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 ☐ Other _____

Are you receiving treatment by any other health professional? ☐ No ☐ Yes _____

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

1) Primary Insurance Company: _____ Group/Policy: _____ ID: _____

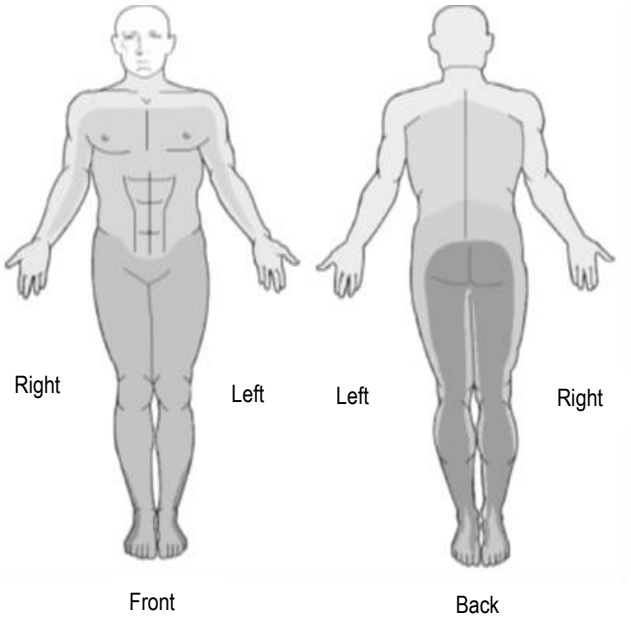
Policy Holder? ☐ Self ☐ Spouse ☐ Parent Name: _____ DOB: m / d / yy

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

Policy Holder? ☐ Self ☐ Spouse ☐ Parent Name: _____ DOB: m / d / yy

Auto Accident Information	WSIB Information
Insurance Company: _____	Is this a New Injury Claim? ☐ Yes ☐ No
Claim No.: _____ Accident Date: m / d / yy	Claim No.: _____ Accident Date: m / d / yy
Adjustor Name: _____ (P) _____	Adjudicator Name: _____ (P) _____
(F) _____	(F) _____

In the diagram, using the symbols below, mark the areas on your body that you feel best represents the location and type of pain or sensation you are *currently* experiencing.



0 ——————————— **10**

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

Tight/Stiff	(**X**)	Sharp	(*I*)
Burning	(**O**)	Numbness	(●)

Use the symbols above to indicate the type of pain or sensation you are currently experiencing

Please check the following health conditions/procedures that apply to **you**, both past (**X**) and present (✓)

- ☐ Abdominal Pain
- ☐ Arthritis
- ☐ Chronic Pain
- ☐ Diabetes
- ☐ Fatigue/Weakness
- ☐ Fracture
- ☐ Sensitivities/Allergies
- ☐ Ear Problems
- ☐ Headache/Migraine
- ☐ Heart Disease/Attack
- ☐ Hyper/Hypo- Tension
- ☐ Joint Pain/Stiffness
- ☐ Kidney Problems
- ☐ Low Back Pain
- ☐ Loss of Sensation
- ☐ Vision Loss/Problems
- ☐ Muscle Cramps
- ☐ Neck Pain/Stiffness
- ☐ Numbness/Tingling
- ☐ Osteoporosis
- ☐ Poor Circulation/Bruising
- ☐ Rheumatoid Arthritis
- ☐ Cancer
- ☐ Varicose Veins/Phlebitis
- ☐ Scoliosis
- ☐ Sciatica
- ☐ Spinal Cord Injury
- ☐ Sprain/Strain
- ☐ Stroke/Aneurysm
- ☐ Thyroid Disease
- ☐ Pacemaker
- ☐ Other _____

Infections: ☐ Hepatitis ☐ Skin Condition ☐ TB ☐ HIV ☐ Herpes ☐ Other Gynecological Infections _____

Respiratory: ☐ Chronic Cough ☐ Shortness of Breath ☐ Bronchitis ☐ Asthma ☐ Emphysema

Are you pregnant? ☐ No ☐ Yes How far along?_____ How is your general health? _____

Do you take any medications? ☐ No ☐ Yes _____

Surgery History? _____

Please check the health conditions that apply to your immediate family, both past (X) and present (✓)

☐ Cancer _____ ☐ Diabetes _____ ☐ Stroke/Aneurysm _____

☐ Heart Disease _____ ☐ Cholesterol _____ ☐ High Blood Pres. _____

☐ Respiratory Problems _____ ☐ Arthritis _____ ☐ Other _____

OUR POLICIES

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:*_____

Cancelation Policy

DUSK PHYSIOTHERAPY enforces a strict cancellation policy to ensure that any given patient can receive the care they need on any given day. Therefore, DUSK PHYSIOTHERAPY requires **24 hours' notice** for cancellation of any appointment. A fee of **50% of the scheduled visit** will be charged for missed appointments without a **24 hour** notification. This fee is not covered by insurance plans and thus must be paid at the patient's 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 Waiver

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. As the patient, you understand and are 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 herniation, as a result of manual therapy techniques. While extremely rare, there are reported cases of stroke associate 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 treatment for many neck and 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 Waiver

The patient expressively acknowledges that he/she may be engaging in physical exercise while attending the clinic's facilities, which could cause injury to the patient. The patient hereby states that he/she is and will be, voluntarily participating in these activities and the patient hereby assumes all risk of injury which might result from these activities. The patient hereby waives and releases any and all claims that he/she now has or may have against DUSK PHYSIOTHERAPY, its employees or agents for injury sustained by the clinic as a result of these physical exercises and activities. The patient hereby acknowledges that he/she has carefully read this waiver and release and thus fully understands that it is a release of liability of DUSK PHYSIOTHERAPY 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, understood, and agreed 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 to 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/yy)

PAYMENT OPTIONS AND ACKNOWLEDGMENT

Please Note: Payment method selected will be dependent on your insurance. Claims submitted by the clinic (SRA/AOB/MVA/WSIB) will require a valid credit card to be kept on file.

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

☐ Service Rendered Agreement (SRA): Invoices will be processed by DUSK PHYSIOTHERAPY and sent to the patient's extended health care provider via mail or online (i.e. Telus Health E-Claims). The patient will be charged any outstanding balances on their account for services rendered and/or products received and reimbursed directly by their insurance company.

☐ Assignment of Benefits (AOB): Invoices will be processed by DUSK PHYSIOTHERAPY and sent to the patient's extended health care provider via mail or online (i.e. Telus Health E-Claims) the patient will sign all necessary insurance forms allowing the "authorization of payment" from the insurance company directly to DUSK PHYSIOTHERAPY for all services rendered and/or product received.

☐ 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.

*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 that I may at any time, request any paid or unpaid invoices to my account. While DUSK PHYSIOTHERAPY may record insurance information, the **PATIENT** is ultimately responsible for tracking their services, billings, and coverage limitations. I have read and agreed to the above mentioned payment option(s).*

_____ _____

Patient Signature Date (m/d/yy)

CREDIT CARD INFORMATION

Claims submitted by the clinic on behalf of patients and/or insurance plans 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. Credit card information will be kept strictly confidential and will only by charged for outstanding amounts owed for services or products that have been rendered or provided.

I have read and agreed to the above mentioned payment option(s) and thus allow DUSK PHYSIOTHERAPY to debit my credit card for any outstanding balances as they are incurred on my account as set out in this policy.

_____ _____ _____ _____

Credit Card Number Type 3 Digit CSC Code Card Expiry Date

_____ _____

Patient Signature Date (m/d/yy)