



# Essential Physiotherapy & Wellness

## Essential Physiotherapy – Contact Information

Name: \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Doctor Phone/Address: \_\_\_\_\_

Date of Birth (dd/mmm/yyyy): \_\_\_\_\_ Occupation: \_\_\_\_\_

**IS YOUR VISIT THE RESULT OF A CAR ACCIDENT OR WORKPLACE INJURY?** ☐ Yes ☐ No

Email Address: \_\_\_\_\_

By signing below you understand that Essential Physio is compliant with Anti-Spam Legislation. All email contact with you will be for the purposes of your health care such as newsletters, appointments and follow-up. \_\_\_\_\_

## Medical Information Release

I, \_\_\_\_\_, hereby give permission to Essential Physiotherapy to contact and share or receive health information with my family physician, or any other health professional to determine my progress.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Companies We Direct Bill:

- |                                      |                                   |                                      |  |
|--------------------------------------|-----------------------------------|--------------------------------------|--|
| <input type="checkbox"/> Greenshield | <input type="checkbox"/> Sun Life | <input type="checkbox"/> OTIP        | <input type="checkbox"/> Manion Wilkins      |
| <input type="checkbox"/> Blue Cross  | <input type="checkbox"/> Manulife | <input type="checkbox"/> Canada Life | <input type="checkbox"/> Industrial Alliance |

Policy # \_\_\_\_\_ Member ID # \_\_\_\_\_ Workplace \_\_\_\_\_

(Complete if you are not the Benefit holder)

Name of Policy Holder \_\_\_\_\_ Relationship \_\_\_\_\_

Birthdate of Policy Holder \_\_\_\_\_

☐ I have benefits from a different company – Who? \_\_\_\_\_ ☐ Not covered by Benefits





## HEALTH CONSENT FORM (Chiropractic)

*We need your informed consent. This means that we need you to understand the services we provide, the costs, and what we do with the personal information we gather about you. Please ask us if you have any questions.*

### **CONSENT FOR THE COLLECTION OF PERSONAL INFORMATION**

I understand that to provide me with Chiropractic services, Essential Physiotherapy (herein known as the company) will collect some personal information about me. (e.g., name, address, phone numbers, and health history).

I have had the opportunity to review The Company's Privacy Policy about the collection, use, and disclosure of personal information, steps taken to protect the information and my right to review my personal information. I understand how the privacy policy applies to me. I have been given a chance to ask questions I have about the privacy policies and they have been answered to my satisfaction.

I understand that, as explained in the Policies and Procedures for Personal Information, there are some rare exceptions to these commitments.

I agree to The Company collecting, using, and disclosing personal information about me as set out above and in The Company's Privacy Policy.

### **FEE SCHEDULE**

Chiropractic treatments in our clinic are NOT COVERED BY OHIP. Extended Health Insurance coverage for Chiropractic services is provided by various companies and we advise you to determine if you have such coverage (we will be happy to provide you with invoices so you can submit to your insurance company). If you are seeking Chiropractic treatment as a result of a W.S.I.B. claim, or Motor Vehicle Accident, please advise us of such and we will initiate the appropriate billing.

However, please be advised that our contract is with you, the patient, and therefore you are ultimately responsible for payment of treatments rendered. This applies to all coverage methods (ie. Extended Health Care, W.S.I.B, and Motor Vehicle Insurance etc...). Please feel free to direct your questions to our staff. We will make every effort to assist you with your claim. We accept Visa, MasterCard, American Express, Interac, Cheque or Cash.

	<b><u>Chiropractic</u></b>
Initial Assessment	\$100
Subsequent Treatments	\$60
Missed/ No Show Appointments	Full fee
Short Notice Cancells	50% of fee
Cancelled Appointments (with 24 Hours Notice)	No charge

**I also understand that 24 hours notice of cancellation is expected in order to avoid billing my personal account.** By signing below, I intend this consent form to cover the entire course of treatment for my present condition.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

E&OE

## Case History Outline

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Recent Condition/ Injury: ☐ car accident ☐ work accident ☐ other \_\_\_\_\_ Date \_\_\_\_\_

Was the onset of your current problem: ☐ slow ☐ sudden ☐ sudden with locking ☐ traumatic

Family Doctor: \_\_\_\_\_ Age: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_

How long have you had the problem(s)? \_\_\_\_\_

Has the condition occurred before? ☐ Yes ☐ No When? \_\_\_\_\_

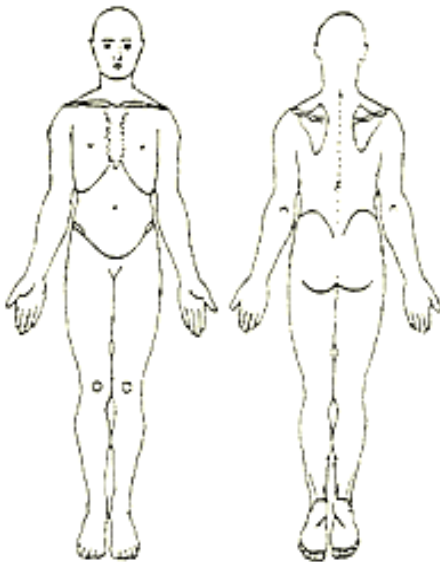
Where was your original pain? \_\_\_\_\_

Has there been any radiation (spread) of your symptoms? ☐ Yes ☐ No Where? \_\_\_\_\_

Have your symptoms changed since the initial onset or injury? ☐ Better ☐ Worse ☐ Same

Did any treatment help to relieve the symptoms? ☐ Yes ☐ No What treatment? \_\_\_\_\_

Does the condition bother you at this exact moment? ☐ Yes ☐ No



PLEASE MARK IN ANY AREAS OF DISCOMFORT

Medications (and reason): \_\_\_\_\_

---



---



---



---



---

**Past Treatment:** (Indicate how many years, months ago for past experiences)

Type (Physio, Chiro, Massage)	Date of Treatment	Results (Positive/Negative)

## Past History:

Check the conditions that you experience *frequently* or have experienced in the past

### Head/Neck:

☐ Headaches

Type \_\_\_\_\_

How often \_\_\_\_\_

☐ Vision Problems

☐ Contact Lenses

☐ Glasses

☐ Ear Aches

### Skin:

☐ Sensitive skin

☐ Rashes, Eruptions

☐ Cold Sores

☐ Herpes

☐ Phlebitis

☐ Bruise easily

☐ Varicose veins

Date diagnosed \_\_\_\_\_

### Hospitalization:

☐ Last Year

☐ 1-2 years ago

☐ 3-5 years ago

### Digestive/ Uro-genital:

☐ Poor appetite

☐ Constipation

☐ Liver/Gall bladder

☐ Kidney/Bladder

☐ Difficult Digestion

### Respiratory:

☐ Chronic cough

☐ Shortness of breath

☐ Smoking

☐ Heavy

☐ Light

☐ Pacemaker

### Muscles/Joints:

☐ Pain

☐ Stiffness

☐ Swelling

☐ Limitation of  
movements

☐ Back pain

☐ Shoulder pain

☐ Neck pain

☐ Osteo Arthritis

Date diagnosed \_\_\_\_\_

Affected Areas \_\_\_\_\_

☐ Rheumatoid pain

Date diagnosed \_\_\_\_\_

### Women Only:

Menstruation

Painful ☐ Heavy ☐ Light ☐

☐ Pregnant

# of weeks \_\_\_\_\_

# of children \_\_\_\_\_

☐ Menopause

### Cardiovascular:

☐ High blood pressure

☐ Low blood pressure

☐ Heart Disease

☐ Poor Circulation

Place \_\_\_\_\_

### Car Accidents (Past):

☐ Yes, date: \_\_\_\_\_

☐ Injuries Sustained: \_\_\_\_\_

☐ NO

### Surgery:

Name \_\_\_\_\_

Why \_\_\_\_\_

When \_\_\_\_\_

### Fractures (Past):

☐ Yes, where \_\_\_\_\_

☐ Pins, plates, screws

### Other conditions:

☐ Sinus

☐ Allergies: type \_\_\_\_\_

☐ Colds

☐ AIDS/HIV

☐ Cancer: type \_\_\_\_\_

☐ Diabetes: type \_\_\_\_\_

None of these conditions affect me: ☐

## Electronic Transmission Authorization and Consent Form

*Instructions: This form must be filled out when claims are submitted electronically by the provider on the patient's behalf. Please retain this form in the patient's file for verification purposes for two years following closure of the patient file.*

### Provider:

Essential Physiotherapy & Birth Essentials  
97 Brant Ave, Brantford  
N3T 3H4  
(519) 752 2151

**Patient:** \_\_\_\_\_

Address: \_\_\_\_\_

City/Province: \_\_\_\_\_

Postal Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Plan Number: \_\_\_\_\_

Certificate / Plan member Number: \_\_\_\_\_

## Consent to Collect and Exchange Personal Information

### Message to the Plan member, Spouse and/or Dependent regarding Personal Information

Personal information that we collect and disclose about you, and if applicable, your spouse and/or dependents, is used by the insurer and/or plan administrator and their service provider(s) for the purposes of assessing your claims, underwriting, investigating, auditing and administering the group benefits plan, including the investigation of fraud and / or plan abuse.

### Authorization and Consent

I authorize my healthcare provider to collect, use and disclose personal information concerning any claims submitted on my behalf with the insurer and/or plan administrator and their service provider(s) for the above purposes.

I authorize the insurer and / or plan administrator and their service provider(s) to:  
use my personal information for the above purposes.

Exchange personal information with any individual or organization, including healthcare professionals, investigative agencies, insurers and reinsurers, and administrators of government benefits or other benefits programs when relevant for the above purposes.

Exchange personal information concerning any claims submitted with the plan member or a person acting on behalf of the plan member. Exchange personal information for the above purposes electronically or in any other manner.

I understand that personal information may be subject to disclosure to those authorized under applicable law.

*I agree that a photocopy or electronic version of this authorization shall be as valid as the original, and may remain in effect for the continued administration of the group benefits plan.*

## **Additional Consent Applicable to Plan Members Only**

I confirm that I am authorized by my spouse and/or dependents, if any, to disclose personal information about them to the insurer and/or plan administrator and their service provider(s) for the purposes described above and I confirm that my spouse and/or dependents also authorize the insurer and/or plan administrator and their service provider(s) to disclose information about their claims to me, for the purposes of assessing and paying a benefit, if any, and managing the group benefits plan. I also authorize my spouse and/or dependents to assign benefit payments under the plan to the healthcare provider.

In the event there is suspicion and/or evidence of fraud and/or plan abuse concerning claims submitted, I acknowledge and agree that the insurer and/or plan administrator and their service provider(s) may use and disclose relevant personal information to any relevant organization including law enforcement bodies, regulatory bodies, government organizations, medical suppliers and other insurers, and where applicable my Plan Sponsor, for the purposes of investigation and prevention of fraud and/or plan abuse.

If there is an overpayment, I authorize the recovery of the full amount of the overpayment from any amount payable under the group benefits plan, and the exchange of personal information with other persons or organizations, including credit agencies and, where applicable, my Plan Sponsor, for that purpose.

\_\_\_\_\_  
Date:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print

## **Benefit Assignment**

I hereby assign benefits payable for the eligible claims to the Provider responsible for submitting my claims electronically to the group benefits plan and I authorize the insurer/plan administrator to issue payment directly to the Provider. In the event my claim(s) are declined by the insurer/plan administrator, I understand that I remain responsible for payment to the Provider for any services rendered and/ or supplies provided.

I acknowledge and agree that the insurer/plan administrator is under no obligation to accept this Assignment, that any benefit payment made in accordance with this Assignment will discharge the insurer/plan administrator of its obligations with respect to that benefit payment, and that in the event the benefit payment is made to me, the insurer/plan administrator will also be discharged of its obligation with respect to that benefit payment.

I understand that this Assignment will apply to all eligible claims submitted electronically by the Provider and that I may revoke it at any time by providing written notice to the insurer/plan administrator.

If I am a spouse or dependent, I confirm that I am authorized by the plan member to execute an assignment of benefit payments to the Provider.

\_\_\_\_\_  
Date:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print