Essential Physiotherapy & Wellness

Essential Physiotherapy – Contact Information

Name: _____ Occupation: _____

Address: _____City:_____Postal Code: _____

Phone: (1st Preference) _____ (2nd) _____ (3rd) _____

Family Doctor: _____ Doctor Phone/Address: _____

Date of Birth (dd/mmm/yyyy):_____ How did you hear about us? _____

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 (we will require a photocopy of your card):

☐ Greenshield ☐ Sun Life ☐ OTIP

☐ Blue Cross ☐ Great West/Canada Life ☐ Manulife

Policy #_____ Member ID # _____ Employer Name _____

(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? _____ ☐ I do not have Benefits

Essential Physiotherapy & Wellness

Confidential Health History Outline

An accurate health history is important to ensure that it is safe for you to receive massage treatment. If your health status changes in the future, please let the therapist know. All information gathered is confidential at all times except as law requires. Please fill out this form fully and accurately to help create a safe and effective treatment.

Name: _____ Todays date: _____

Date of Birth: _____ Occupation: _____

Have you had a massage before? _____ How did you hear about us? _____

Primary Complaint: _____

Type of Pain (achy, shooting, dull, etc.) _____

Does the Pain Radiate or travel? Yes ☐ No ☐ If so, where to? _____

What tends to aggravate the pain? _____

What tends to relieve the pain? _____

Other Complaints: _____

What are you goals for treatment? _____

Please indicate any conditions you are experiencing or have experienced in the past:

Musculoskeletal
- ☐ Bone/Joint disease
- ☐ Tendinitis
- ☐ Bursitis
- ☐ Fractured Bones
- ☐ Carpel Tunnel
- ☐ Sprain/Strain
- ☐ Spasm/Cramp
- ☐ Dislocations
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Headaches
- ☐ Low Back Pain
- ☐ Hip Pain
- ☐ Neck Pain
- ☐ Shoulder Pain
  - ☐ Arm Pain
  - ☐ Hand/Wrist Pain
  - ☐ Other: _____

Respiratory
- ☐ Chronic Cough
- ☐ Shortness of Breath
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema
- ☐ Sinus Problem
- ☐ Other: _____

Cardiovascular
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ CCHF
- ☐ Heart Attack
- ☐ Phlebitis
- ☐ Stroke/CVA
- ☐ Raynaud's
  - ☐ Varicose Veins
  - ☐ Blood Clots
  - ☐ Other: _____

Digestive
- ☐ Constipation
- ☐ Gas
- ☐ Diverticulitis
- ☐ Crohn's Disease
- ☐ Ulcerative Colitis
- ☐ Irritable Bowel Syndrome

Infections
- ☐ Hepatitis
- ☐ TB
- ☐ HIV
- ☐ Other: _____

Reproductive
- ☐ Pregnant (due: _____)
- ☐ Menstrual Pain
- ☐ PMS
- ☐ Other: _____

Other
- ☐ Loss of Sensation Where: _____
- ☐ Diabetes
- ☐ **Allergies** _____
- ☐ Epilepsy
- ☐ Cancer/Tumors
- ☐ Hearing Problems
- ☐ Vision Problems
- ☐ Sleep Disorders
- ☐ Addictions

Skin
- ☐ Rashes
- ☐ Eczema
- ☐ Psoriasis
- ☐ Warts
- ☐ Burns
- ☐ Other: _____

Are you Currently seeing a Medical Practitioner? (includes Chiro, Physio, etc.) _____

Current Medications: _____ What it treats: _____

Any Previous Injuries (Car, Sports, Fall etc.): _____

Any Surgeries (include description & approx. date): _____

Presence of: ☐ Internal Pins ☐ Wires ☐ Artificial Joints ☐ Special Equipment

Any Other Comments: _____

_____

Essential Physiotherapy & Wellness

Fees & Cancellation Policy

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, including Extended Health Insurance, MVA insurance, etc. We will make every effort to assist you with your claim.

Massage Rates

30 minutes	$65.00 + HST = $73.45
45 minutes	$80.00 + HST = $90.40
60 Minutes	$95.00 + HST = $107.35

Cancellation Policy

As a courtesy, please cancel your appointment as soon as you are aware that you can not make it. If you miss an appointment without giving 24 hours notice you will be **charged 50%** of the rate for booked appointment. There will be no exceptions, as your time slot could have been filled by another client.

I have read and understood the above.

Name (print clearly): _____

Signature: _____ Date: _____

Consent to Assessment and Treatment

A short assessment may be performed before and after each massage therapy treatment to properly record any progress you may be making through your treatment plan. I understand that if clinically indicated assessment and Treatment of sensitive areas such as breast, chest wall, gluteal, and upper inner thigh may be completed by the Registered Massage Therapist. A full treatment plan will be discussed and agreed upon by both the client and the Registered Massage Therapist before treatment of these sensitive areas or any part of the client's body.

All types of physical therapies have possible side effects and risk factors associated with it. It is important to complete the health history form accurately for the massage therapist to decide if treatment is suitable for your body type and your unique health status.

I have read the above statements and am aware of the therapists' intentions for the treatments to follow. I hereby give my written consent to receive massage therapy treatments.

Signature: _____ Date: _____

E&OE

Electronic Transmission Authorization and Consent Form

(Complete if you have Benefits We Direct bill) *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