

***CONSENT FORM:*** *We would like* ***your informed consent so you understand the services we are providing to you, the cost involved, and what we do with your personal information.***

1. **Consent for Treatment**: I hereby give permission to Physiocare to;

* Treat me with a program of Physiotherapy, Chiropractic, Massage Therapy, Osteopathy and/or acupuncture which will be explained to me by a health care professional.
* Contact my doctor(s) to report or gather information on my diagnosis, treatment plans, and progress.
* Report assessment findings, treatment plan, and progress to the appropriate third parties. These may include insurance companies, legal counsel, and other related parties.
* Have support personnel carry out components of the treatment plan as assigned and supervised by a physiotherapist.

1. **Consent for Cost**: Our fees are posted at reception. Physiocare will;

* Send the invoice directly to my insurance company and I will authorize them to forward payment directly to Physiocare *OR*
* Invoice me and I will remit payment to the clinic. I will submit the invoice to my insurance company for reimbursement, if applicable.

If my insurance company does not honor the release authorization and forwards the payment to me instead, I will forward this payment to the clinic.

1. **Co-Payment**: I understand that I am responsible for paying the annual deductible and co-payment, which my insurance company may deduct for my medical treatments.
2. **Consent for Collection of Personal Information:**

* I understand that Physiocare will collect my personal information (i.e. address, health history, etc.…) in order to provide me with health care goods and services.
* I am aware that PhysioCare has a standard healthcare Privacy Policy that outlines 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.

The purpose of the above is to facilitate effective assessment, treatment, or other services for me. Contact with any of the above may occur via mail, email, fax, or voice. I understand all information will be kept confidential.

By signing below, I am indicating that I have read, understood, and give consent to the above

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

*If under 16 years of age, signature of parent/guardian is required.*

**MEDICAL HISTORY FORM**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_

**Are you latex sensitive? Yes No Do you have a pacemaker? Yes No**

**WOMEN:** **Are you currently pregnant or think you might be pregnant?** **Yes No**

**Have you had a change in menstrual cycle? Yes No NA**

**REVIEW of SYSTEMS**

**Have you RECENTLY had any of the following (check all that apply)?**

❑ excessive fatigue ❑ numbness or tingling ❑ unexplained weight loss/gain

❑ fever, sweats or chills ❑ muscle weakness ❑ nausea/vomiting

❑ difficulty maintaining balance while walking ❑ dizziness/lightheadedness ❑ change in mental status

❑ urinary urgency/ incontinence ❑ severe pain at night ❑ change in appetite

❑ change in bowel/bladder function ❑ recent illness

**Do you have now or have a history of any of the following conditions (check all that apply)?**

❑ cancer ❑ kidney disease ❑ hypoglycemia

❑ high cholesterol ❑ difficulty initiating urine ❑ diabetes

❑ heart disease (coronary artery disease) ❑ prostate problems ❑ thyroid disease

❑ chest pain/angina ❑ urinary urgency/incontinence ❑ anemia

❑ heart attack (MI) ❑ bladder/urinary tract infection ❑ blood clots

❑ high blood pressure ❑ hepatitis or liver disease ❑ swelling of feet/legs

❑ congestive heart failure ❑ seizure disorder ❑ fibromyalgia

❑ abnormal heart rhythm ❑ headaches ❑ osteoarthritis

❑ fainting ❑ stroke/TIA ❑ rheumatoid arthritis

❑ shortness of breath ❑ neuropathy ❑ osteoporosis

❑ asthma ❑ frequent migraines ❑ fractures

❑ pneumonia ❑ neurological disorder ❑ artificial joints

❑ tuberculosis ❑ difficulty swallowing ❑ anxiety

❑ lung disease ❑ specific food intolerances ❑ depression

❑ smoker/tobacco user ❑ heartburn/indigestion/reflux ❑ chemical dependency

❑ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY HISTORY**

**Do any immediate family (parents, brothers, sisters or children) have a history of any of the following?**

❑ lung disease ❑ cancer ❑ diabetes

❑ heart problems ❑ stroke ❑ thyroid problems

❑ high blood pressure ❑ kidney disease ❑ blood clots

❑ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Fall Risk**

Have you fallen in the last year? Yes No If so, how many times? \_\_\_\_\_\_\_

Have any of these falls resulted in an injury? Yes No

Do have a fear of falling? Yes No

Do you experience dizziness or vertigo? Yes No

Do you have vision problems not corrected by glasses? Yes No

During the past month have you been feeling down, depressed or hopeless? **YES NO**

During the past month have you been bothered by having little interest or pleasure in doing things? **YES NO**

**Please list any medications you are currently taking:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ALLERGIES:** **Please list any medication(s) you are allergic to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

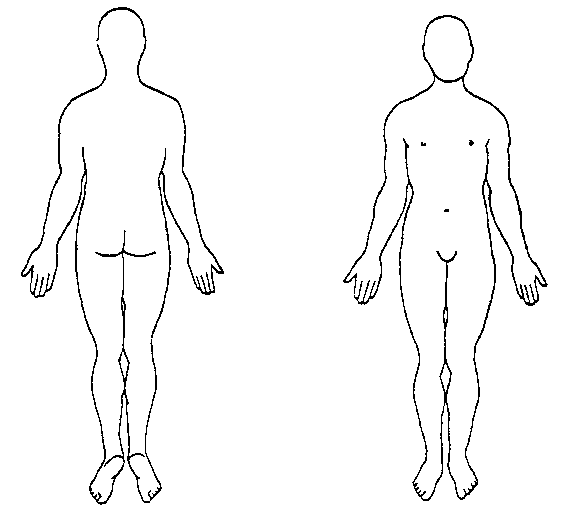
Do you now or have you ever taken steroid medications for any medical conditions? **YES NO**

Are you taking blood thinning medications or aspirin/ibuprofen for any medical conditions? **YES NO**

Have you had surgery for this condition? Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list any other surgeries or other conditions for which you have been hospitalized:**

**Are you on a work or activity restriction from your doctor? Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Body Chart:**

Please mark the areas where you

currently having symptoms on the chart to the right:

* **Shooting/sharp pain**

**Ο Dull/aching pain**

**||| Numbness/Tingling**

For the therapist:

+/- Cough/Sneeze

+/- Saddle Anesthesia

+/- Bowel/Bladder Changes

+/- Numbness/Tingling

**My symptoms currently:** ❑ Come and go ❑ Are Constant ❑ Are constant, but change with activity

**When did your present symptoms start?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How did your symptoms begin?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are your symptoms: ❑ Getting Better ❑ Getting Worse ❑ staying about the same?**

**What tests have been performed for this problem? (X-ray, MRI, etc.)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Treatment received so far for this problem (injections, etc.)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you ever had this problem before?** **❑ Yes ❑ No** **When**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Aggravating Factors:** Identify the important positions or activities that make your symptoms **worse**:

**Ex: Lying down Standing Walking Sitting \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Other activities/positions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Easing Factors:** Identify the important positions or activities that make your symptoms **better**:

Activities/positions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does coughing, sneezing or taking a deep breath aggravate your symptoms? YES NO

Does bending, sitting, lifting or twisting your back aggravate your symptoms? YES NO

Has there been any change in bowel habit since onset of your symptoms? YES NO

Does eating certain foods aggravate your symptoms? YES NO

Has there been any weight change since onset of symptoms? YES NO

**How are you currently able to sleep at night due to your symptoms?**

❑ No problem sleeping ❑ Difficulty falling asleep ❑ Awakened by pain ❑ Sleep only with medication

**When are your symptoms worst?** ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After exercise

**When are your symptoms the best?** ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After exercise

**Using the 0 to 10 the scale, with 0 being *“no pain”* and 10 being the *“worst pain******imaginable”* please describe:**

Your present level of pain: \_\_\_\_\_\_\_\_\_

The best your pain has been in the past 24 hrs.: \_\_\_\_\_\_\_ The worst your pain has been in the past 24 hrs.: \_\_\_\_\_\_\_

**Patient/Guardian signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Therapist signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_ Time\_\_\_\_\_\_\_\_\_\_\_**

I have reviewed the above medical history form with the patient

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB (m/d/yr): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Prov: \_\_\_\_\_\_\_\_\_ Tel (h): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Postal Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel (c): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Dr.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referring Dr.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Dr. Tel: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referring Dr. Tel: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about PhysioCare? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Company #1**

Insurance Co: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_ Pol. Holder DOB (m/d/yr.):\_\_\_\_\_

Physio: max/yr: \_\_\_\_\_\_ @ \_\_\_\_\_\_% Limit per visit: \_\_\_\_\_\_\_\_\_\_\_\_ Dr. Referral Req’d: Y/N

Massage: max/yr: \_\_\_\_\_\_@ \_\_\_\_\_\_% Dr. Referral Req’d: Y/N

Chiropractor: max/yr: \_\_\_\_\_\_ @ \_\_\_\_\_\_% Limit per visit: \_\_\_\_\_\_\_\_\_\_\_\_Dr. Referral Req’d: Y/N

Orthotics: max/yr: \_\_\_\_\_\_ @ \_\_\_\_\_\_ % Dr. Referral Req’d: Y/N Pair Limit/yr: \_\_\_\_\_\_\_\_\_\_

**Insurance Company #2**

Insurance Co: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_ Pol. Holder DOB (m/d/yr):\_\_\_\_\_

Physio: max/yr: \_\_\_\_\_\_ @ \_\_\_\_\_\_% Limit per visit: \_\_\_\_\_\_\_\_\_\_\_\_ Dr. Referral Req’d: Y/N

Massage: max/yr: \_\_\_\_\_\_@ \_\_\_\_\_\_% Dr. Referral Req’d: Y/N

Chiropractor: max/yr: \_\_\_\_\_\_ @ \_\_\_\_\_\_% Limit per visit: \_\_\_\_\_\_\_\_ Dr. Referral Req’d: Y/N

Orthotics: max/yr: \_\_\_\_\_\_ @ \_\_\_\_\_\_ % Dr. Referral Req’d: Y/N Pair Limit/yr: \_\_\_\_\_\_\_\_\_\_

**M.V.A. (photo ID required)**

Insurance Co: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Adjuster: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Claim #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prov: \_\_\_\_\_\_\_ Postal Code: \_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Accident (m/d/yr): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FOR OFFICE USE ONLY: Photo ID checked by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_staff initial**

**W.S.I.B.**

Date of Accident (m/d/yr): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Claim #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Case Manager: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prov: \_\_\_\_\_\_\_ Postal Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Nurse Consultant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tel: \_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Electronic Transmission Authorization and Consent Form**

**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 Name:

CLINIC 1801 Dundas St. E, Whitby

PHONE 905-240-6566

FAX 905-240-6466

EMAIL physoiocarewhitby@yahoo.ca



**24 HOUR CANCELLATION POLICY**

**FOR PHYSIOCARE PHYSIOTHERAPY**

We value each of you as individuals and welcome the responsibility and privilege of caring for and supporting you, as health care professionals.

Our goal is for each client to be seen and treated in a timely and efficient manner. With that as our focus, we want to remind everyone of our Clinic policy concerning cancelled appointments.

There will be a standard appointment fee of 50% of selected treatment applied to your account for cancellations received without 24-hour notification. For missed appointments the standard fee will be 100% of selected services.

We do have voicemail and email which we check regularly so a message can be left at any time of the day or night.

Yours in Health,

PhysioCare Physiotherapy Team

( ) I have read and agree to this cancellation policy.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: (day/month/year): \_\_\_/\_\_\_/\_\_\_\_\_\_

Please print

Patient’s D.O.B. (day/month/year): \_\_\_/\_\_\_/\_\_\_\_\_\_

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_