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.

2. **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.

3. **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.

4. **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
❑ fever, sweats or chills
❑ difficulty maintaining balance while walking
❑ urinary urgency/ incontinence
❑ change in bowel/bladder function
❑ numbness or tingling
❑ muscle weakness
❑ dizziness/lightheadedness
❑ severe pain at night
❑ recent illness
❑ unexplained weight loss/gain
❑ nausea/vomiting
❑ change in mental status
❑ change in appetite

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

❑ cancer
❑ high cholesterol
❑ heart disease (coronary artery disease)
❑ chest pain/angina
❑ heart attack (MI)
❑ high blood pressure
❑ congestive heart failure
❑ abnormal heart rhythm
❑ fainting
❑ shortness of breath
❑ asthma
❑ pneumonia
❑ tuberculosis
❑ lung disease
❑ smoker/tobacco user
❑ Other _____
❑ kidney disease
❑ difficulty initiating urine
❑ prostate problems
❑ urinary urgency/incontinence
❑ bladder/urinary tract infection
❑ hepatitis or liver disease
❑ seizure disorder
❑ headaches
❑ stroke/TIA
❑ neuropathy
❑ frequent migraines
❑ neurological disorder
❑ difficulty swallowing
❑ specific food intolerances
❑ heartburn/indigestion/reflux
❑ hypoglycemia
❑ diabetes
❑ thyroid disease
❑ anemia
❑ blood clots
❑ swelling of feet/legs
❑ fibromyalgia
❑ osteoarthritis
❑ rheumatoid arthritis
❑ osteoporosis
❑ fractures
❑ artificial joints
❑ anxiety
❑ depression
❑ chemical dependency

FAMILY HISTORY

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

❑ lung disease
❑ heart problems
❑ high blood pressure
❑ cancer
❑ stroke
❑ kidney disease
❑ Other_____
❑ diabetes
❑ thyroid problems
❑ blood clots

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**

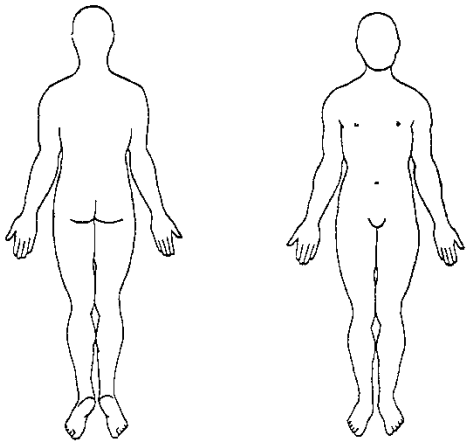
Please list any medications you are currently taking:

_____ _____
_____ _____
_____ _____
_____
_____
_____

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**
O Dull/aching pain
||| Numbness/Tingling



For the therapist:
+/- Cough/Sneeze
+/- Saddle Anesthesia
+/- Bowel/Bladder

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

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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

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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

t: 905-240-6566 f: 905-240-6466

PhysioCare
PHYSIOTHERAPY
Physiotherapy | Acupuncture | Massage Therapy | Chiropractic Therapy

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

t: 905-240-6566 f: 905-240-6466

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: _____