CLAYTON HEIGHTS
SPORTS AND THERAPY CENTER

Reset

105-18640 Fraser Hwy Surrey BC V3S 7Y4
604 579 0105

First Name _____ Last Name _____

BC Care Card No. _____-_____-_____ Birth Date (MDY) _____/_____/_____

Address _____City _____ Postal Code _____
Home Ph _____ Wk Ph _____ Cell Ph _____
Best number to reach you at? _____

Email _____Courtesy Reminder- **Email**_____ **Text (*cell carrier needed*)** _____

Referring Dr. _____ Phone _____
Family Dr. _____ Phone _____

How did you hear about us? Doctor _____ Walked in _____ Drive by/Signs _____
Google_____ Yellow Pages_____ Friend Referral (name): _____

Steve Nash Member: Y ☐ N☐ Would you like a free 10 day pass to Steve Nash: Y ☐N ☐

Patient Consent

By signing below I consent to treatment. During the initial assessment I will be assessed and a treatment plan will be discussed, and explained. I can ask question and have a right to be informed of the treatment provided. I may stop treatment at any time.

I have read the posted fees and agree to pay those fees for treatment. I understand that payment for all treatment, whether private or insured, is ultimately the responsibility of the patient.. It is the patients' responsibility to keep track of their claim status and number of visits that have been approved. In order to receive the insurer rates the clinic must confirm that you are approved for coverage directly from the insurer. Any fees not covered or refused from any third party or insurer is immediately due to the clinic at the private rates posted above. I understand that any outstanding balances are due before I may start my next treatment.

Extended Benefits Authorization

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 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.

Cancellation/No Show Policy: Your appointment time has been reserved for you. In courtesy of your therapist and fellow patients, we ask that you provide us with 24 hours' notice of cancellation, or a cancellation fee will be charged. If you are late for your scheduled appointment please be advised that your appointment will end at the time it was originally booked for and the price of the original duration will be charged. There is an option to choose to receive a reminder by email or text message. This reminder is a courtesy reminder for an appointment and time slot already pre scheduled. In no way by not receiving a reminder shall the cancellation policy by void.

Physiotherapy late cancellation/No Show: $30 RMT late cancellation: full amount of original appointment

By signing below I have read and understand Clayton Heights Sports and Therapy Center's Patient consent, benefits authorization, cancellation policy and agree to its terms.

Signature: _____ **Date:** *11/16/2014*

24hours notice is required to cancel an appointment

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Extended Health Plans

Pacific Blue Cross, Great-West Life, Sun Life, Manulife, Standard Life, Industrial Alliance, Johnson Inc, Chambers of Commerce, Maximum Benefit & Johnston Group Patients

Every extended health plan is different. Each company choses the coverage that they provide to their employees.
We bill Pacific Blue Cross, Great West Life, Industrial Alliance, Sunlife, Manulife,Chambers of Commerce, Standard Life, Cowan, Johnson Inc, Maximum Benefit & Johnston Group.
If your insurer is not on the list, the fees are payable at the private rate and it is the patient's responsibility to submit them to the insurance company. *It is the patient responsibility to know the coverage and limitations of their extended health plan.*

We can only direct bill the amount that is provided by the insurance company, any balances not covered will need to be paid at the time of your v*isit,* and then manually submitted to your carrier by you.

Please bring your card in with you on your first visit.

L / . /

Claim #_____ Date of Accident _____

Adjuster _____Adjuster's phone _____

Claim center _____ Email: _____

Do you have a lawyer that represents your claim? Law Firm _____

Lawyer_____ Phone Number_____

A doctor's referral for physiotherapy regarding the MVA is mandatory. ICBC patients must pay a Surcharge per visit. Any fees not covered by ICBC, or refused by ICBC are immediately payable by the patient at the private fee. It is the patients' responsibility to keep track of their claim status and number of visit _____

WCB (physio only)

Claim number	Date of injury (yyyy-mm-dd)		
Claim owner	Attending physician		
Company name			
Worksite address	City	Province	Postal code
Company phone number (include area code)	Fax number (include area code)		
Contact name	Contact job title		
Contact phone number (include area code)	Worker occupation		
Usual pre-injury work schedule (days and hours) Days per week / Hours per day	Comments (if applicable)		
Is worker currently working? Yes ☐ No ☐	Are there confirmed light or modified duties available? Yes ☐ No ☐ Unknown ☐		

The cancellation policy applies to all WCB visits

RCMP/DVA

ID#: **R**_____ Unit: _____

Collator: _____ Division: _____ Ph: _____

Authorization is required from Blue Cross in order for you to have visits covered. Any fees not covered by Blue Cross are immediately payable by the patient at the private fee to the clinic. The clinic will direct bill Blue Cross for physiotherapy and registered massage therapy covered under the insurance plan

MSP

Patients who qualify for premium assistance through the BC medical Plan are entitled to 10 visits total per calendar year including physiotherapy/ chiropractor/ podiatry/ naturopath and massage. Any fees over the limit, or refused by MSP are payable immediately by the patient.

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CONFIDENTIAL PATIENT HISTORY FORM

Name _____ Gender ***Female/Male*** AGE _____

Family Doctor _____ Phone _____

Referring Professional_____ Phone _____

Occupation _____Are you currently working: ***Yes/No***

Work Duties- (describe)_____

Please indicate if you believe any of the following apply to you:

Head/Neck	Current	Past
Headaches		
Frequency_____	☐	☐
Migraines	☐	☐
Frequency_____		
Head Injury	☐	☐
Concussion	☐	☐
Jaw/TMJ	☐	☐
Whiplash	☐	☐
Vision	☐	☐
Ear problems	☐	☐
Fainting	☐	☐
Dizziness	☐	☐
Sinus	☐	☐
Facial pain	☐	☐
Stroke	☐	☐
Other Neurological Issues	☐	☐
Cardiovascular		
High blood pressure	☐	☐
Low blood pressure	☐	☐
Chronic Congestive heart Failure	☐	☐
Heart Attack date: _____	☐	☐
Stroke date: _____	☐	☐
Cardiovascular aneurysm date: _____	☐	☐
Pacemaker/other device	☐	☐

Birth & Childhood	Current	Past
Birth Trauma	☐	☐
Feeding problems	☐	☐
Colic	☐	☐
Recurrent ear infections	☐	☐
Developmental delays	☐	☐
Behavioural	☐	☐
Restlessness	☐	☐
ADD/ADHD	☐	☐
Learning problems	☐	☐
Eye motor problems	☐	☐
PDD/autism	☐	☐
Other Conditions		
Osteoporosis	☐	☐
HIV	☐	☐
TB	☐	☐
Skin conditions	☐	☐
Hepatitis	☐	☐
Diabetes	☐	☐
Epilepsy/seizures	☐	☐
Cancer	☐	☐
Arthritis	☐	☐
Insomnia	☐	☐
Fatigue	☐	☐
Numbness/tingling	☐	☐
Hyper/Hypo Thyroid	☐	☐

Respiratory	Current	Past
Chronic conditions	☐	☐
Shortness of breath	☐	☐
Bronchitis	☐	☐
Asthma	☐	☐
Emphysema	☐	☐
Gastrointestinal		
Heartburn	☐	☐
Nausea	☐	☐
Constipation	☐	☐
Haemorrhoids	☐	☐
Diarrhea	☐	☐
Ulcer	☐	☐
Irritable Bowel Syndrome	☐	☐
Colitis	☐	☐
UTI / Bladder infections	☐	☐
Other Urinary Condition	☐	☐
Physical		
Joint dislocation	☐	☐
Bone Fracture	☐	☐
Rods/Pins/Plates/Shunts	☐	☐
Implants_____	☐	☐
Transplant_____	☐	☐
Corrective Lenses/ Contacts ☐	☐	☐
Spinal Injury	☐	☐
Varicose veins	☐	☐

Please list any medications you presently take:

_____

Known Allergies (Including medications, foods, seasonal, oils and lotions, etc.)

_____

Are you a Smoker? ***Yes/ No*** **Do you Live with a smoker?** ***Yes/ No***

Do you drink Alcohol ? ***Yes/No***

Do you have a family history of medical conditions? ***No***

Please list: _____

Have you ever been hospitalized, had any major accidents, illnesses) ***Yes/No***

Describe: _____

_____

List all surgeries (including abdominal) and year of surgery:_____

_____

_____

List any activities, sports, or hobbies that you participate in regularly
(ie. Jogging, hockey, crafts, computer, etc.)

_____

_____

List any non-prescription vitamins, minerals, or other supplements you are taking:

_____

_____

Please CIRCLE the answer closest to how you PRESENTLY feel: (1= poor, 5= excellent)

Quality of sleep	1	2	3	4	5
Energy Level	1	2	3	4	5
Eating Habits	1	2	3	4	5
Stress Level	1	2	3	4	5
Exercise Habits	1	2	3	4	5

1 2 3 4 5

Hours of sleep per night (approx..) 1 2 3 4 5 6 7 8 9 10

Number of meals you regularly eat per day? 1 2 3 4 5

Number of times you exercise per week? 1 2 3 4 5

Current Condition

Dominant Hand L ☐ R ☐

Please describe your current Condition & Symptoms:_____

_____

How long have you had this Condition?_____

How did it start? _____

Is it getting better, worse or the same_____

What aggravates it? (ie which movements, sleeping)_____

_____

What relieves it? (position, heat, ice, medications)_____

Have you had a problem like this before?_____ **When?**_____

How was it treated:

Massage Therapy	☐	Chiropractor	☐	Was it resolved:
Physiotherapy	☐	Accupuncture	☐	***Yes/No***
Naturopath	☐	Other	☐	

Have you had any X-rays/MRI/CT scans etc.? ***Yes/No***

When? _____

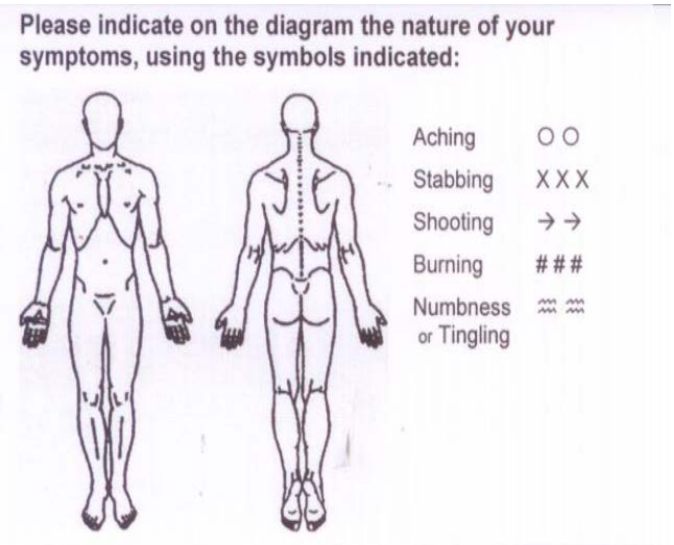
Since the condition started have there been any changes to the bladder or bowel: ***No***

Are you suffering from dizziness? ***No***

How often _____

Do you have drop attacks? ? ***No***

How often _____



Pain Scale 1-10 (1=none, 10= I need to go to the hospital)

I authorize the clinic and its associated practitioner's to collect my personal and medical information as documented above in order access, diagnose, and develop a treatment plan and provide treatment. I authorize the clinic and its associated practitioner's to communicate with my referring MD as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

Signature: _____ **Date:** ***11/16/2014***

Email **Click to Print**