

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 be 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: _____

24hours notice is required to cancel an appointment

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 chooses 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 visit, and then manually submitted to your carrier by you.

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

@ #

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)		Comments (if applicable)	
Days per week	Hours per day		
Is worker currently working?		Are there confirmed light or modified duties available?	
Yes	No	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.

CONFIDENTIAL PATIENT HISTORY FORM

Name _____ Gender _____ AGE _____

Family Doctor _____ Phone _____

Referring Professional _____ Phone _____

Occupation _____ Are you currently working: _____

Work Duties- (describe) _____

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

<u>Head/Neck</u>	<u>Current</u> <u>Past</u>	<u>Birth & Childhood</u>	<u>Current</u> <u>Past</u>	<u>Respiratory</u>	<u>Current</u> <u>Past</u>
Headaches Frequency _____		Birth Trauma		Chronic conditions	
Migraines Frequency _____		Feeding problems		Shortness of breath	
Head Injury		Colic		Bronchitis	
Concussion		Recurrent ear infections		Asthma	
Jaw/TMJ		Developmental delays		Emphysema	
Whiplash		Behavioural			
Vision		Restlessness		<u>Gastrointestinal</u>	
Ear problems		ADD/ADHD		Heartburn	
Fainting		Learning problems		Nausea	
Dizziness		Eye motor problems		Constipation	
Sinus		PDD/autism		Haemorrhoids	
Facial pain		<u>Other Conditions</u>		Diarrhea	
Stroke		Osteoporosis		Ulcer	
Other Neurological Issues		HIV		Irritable Bowel Syndrome	
		TB		Colitis	
		Skin conditions		UTI / Bladder infections	
		Hepatitis		Other Urinary Condition	
		Diabetes			
<u>Cardiovascular</u>		Epilepsy/seizures		<u>Physical</u>	
High blood pressure		Cancer		Joint dislocation	
Low blood pressure		Arthritis		Bone Fracture	
Chronic Congestive heart Failure		Insomnia		Rods/Pins/Plates/Shunts	
Heart Attack date: _____		Fatigue		Implants _____	
Stroke date: _____		Numbness/tingling		Transplant _____ <input type="checkbox"/>	
Cardiovascular aneurysm date: _____		Hyper/Hypo Thyroid		Corrective Lenses/ Contacts <input type="checkbox"/>	
Pacemaker/other device				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?

Do you Live with a smoker?

Do you drink Alcohol ?

Do you have a family history of medical conditions?

Please list: _____

Have you ever been hospitalized, had any major accidents, illnesses) _____

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

Energy Level

Eating Habits

Stress Level

Exercise Habits

Hours of sleep per night (approx..)

Number of meals you regularly eat per day?

Number of times you exercise per week?

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

Naturopath

Other

Have you had any X-rays/MRI/CT scans etc.?

When? _____

Since the condition started have there been any changes to the bladder or

bowel: _____

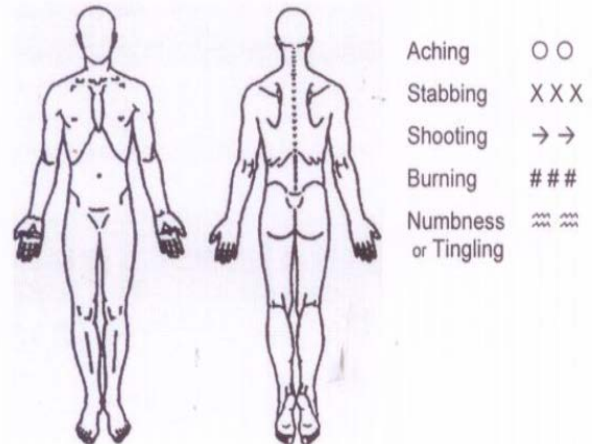
Are you suffering from dizziness?

How often _____

Do you have drop attacks? ?

How often _____

Please indicate on the diagram the nature of your symptoms, using the symbols indicated:



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: _____