CLAYTON HEIGHTS **SPORTS & THERAPY CENTER**

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

First Name ______________________ Last Name ________________________

Email __________________________ Address ________________________

Home Ph _______________________ City______________________________

Cell Ph ______________________ Postal Code_______________________

Birth Date (MDY) ______/______/________ Gender M _____ F ______

BC Care Card No.______________________

Referring Dr. ___________________ Family Dr. _________________________

Phone ________________________ Phone ____________________________

Courtesy Reminder-Email_____ Text _____

How did you hear about us? Doctor ______ Walked in ______ Drive by/Signs ______
Google_____ Yellow Pages_____ Friend____Family_____

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.

Late cancellation/Missed appointment charges are the 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

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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, Greensheild, SSQ, Medavive Bluecross & Johnston Group Patients

Every extended health plan is different. Each company choses the coverage that they provide to their employees.

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.

ICBC

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		

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 to the clinic at the private rate. Patients can call Medical Services to see if they are entitled to premium assistance.

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CONFIDENTIAL PATIENT HISTORY FORM

Name ____ Gender M ____ F ____ AGE __________

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	Current	Past
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	Current	Past
Osteoporosis	☐	☐
HIV	☐	☐
TB	☐	☐
Skin conditions	☐	☐
Hepatitis	☐	☐
Diabetes	☐	☐
Epilepsy/seizures	☐	☐
Cancer	☐	☐
Arthritis	☐	☐
Insomnia	☐	☐
Fatigue	☐	☐
Numbness/tingling	☐	☐
Hyper/Hypo Thyroid	☐	☐
Are you pregnant?	**Y**	**N**
Due date: _______________		
OR trying to get pregnant	**Y**	**N**

Respiratory	Current	Past
Chronic conditions	☐	☐
Shortness of breath	☐	☐
Bronchitis	☐	☐
Asthma	☐	☐
Emphysema	☐	☐

Gastrointestinal	Current	Past
Heartburn	☐	☐
Nausea	☐	☐
Constipation	☐	☐
Haemorrhoids	☐	☐
Diarrhea	☐	☐
Ulcer	☐	☐
Irritable Bowel Syndrome	☐	☐
Colitis	☐	☐
UTI / Bladder infections	☐	☐
Other Urinary Condition	☐	☐

Physical	Current	Past
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 Occasional Do you live with a smoker? Yes No

Alcohol consumption (circle one) None Light Moderate Heavy

Do you have a family history of medical conditions? (Please Circle) **Yes 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/low, 5= excellent/high)

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

Hours of sleep per night (approx...)

Number of meals you regularly eat per day?

Number of times you exercise per week?

Reason For Todays Visit (What would you like worked on)

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
- ☐ Physiotherapy
- ☐ Acupuncture
- ☐ Naturopath
- ☐ Other

Was it resolved:

____

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: _______Yes _______No

Are you suffering from dizziness?______Yes _____ No,

How often ______________________________

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

- Aching O O
- Stabbing X X X
- Shooting → →
- Burning # # #
- Numbness or Tingling ≈ ≈

Pain scale rating ______

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:** ______________