EHC/Private intake form

All information is reserve as part of your confidential patient record.

Personal information

Name: _____

Home Address: _____ Home phone #: _____

Postal Code: _____ Cell Phone #: _____

Date of birth: D ____M____Y____ Age _____ Marital status: M ___ S___ W___ D___

Email address: _____ Occupation: _____

Emergency contact name: _____ Phone #: _____

Family Doctor name: _____ Phone #: _____

Primary concern for today's appointment (Must be Answered)

Did you have any related Pervious Injuries /Surgery? _____

Did you have any imaging test for your current condition?

_____

Lifestyle: Exercise □ Smoke □ Drink □ Drug use □ other:

_____

Health History:

Please check any of the following conditions you have.

□ Pregnancy □History of Cancer □Pacemaker □Any metal in your body □Severe Allergy □Depression/Anxiety

_____

□Loss of consciousness
□Fainting/Dizziness
□Diabetes, (Type 1/Type 2)
□Depression/Anxiety
□Thyroid condition
□Numbness/Pain/ Tingling
□Thrombosis
□ Allergy
□Headache/Migraines
□Loss of sleep
□unexplained weight
□Osteoarthritis
□Sciatica
□Bronchitis

□Chest pain
□High/Low blood Pressure
□High/Low Cholesterol
□Heart attach/stroke
□Pacemaker
□Poor Circulation
□Multiple Sclerosis
□Thyroid Problems
□Fibromyalgia
□Scoliosis
□Rheumatoid Arthritis
□ Osteoporosis
□ Fibromyalgia
□Emphysema

□Epilepsy
□Anemia
□Kidney Problems
□Hepatitis
□ Parkinson's
□HIV
□ Skin Problems
□Chronic Fatigue
□Hearing problems
□Liver Problems
□ Gynecological Problems
□ Asthma
□Shortness of breath

Is there anything else we should know about your health condition? _____

_____

Please list any medication you are currently taking: _____

_____

Disclosing Personal information

Communication is key to safe and effective care. We may need to communicate with your physician or other members of your health care team.

By signing this agreement, I give permission for York-Med physiotherapy and wellness Centre to communicate with other healthcare providers, and third parties involved in my care. I authorize York-Med Physiotherapy and wellness Centre to contact me about my appointments and clinic updates. I understand that my persona information is confidential, and that York-Med physiotherapy and wellness Centre will take the utmost care to safeguard my privacy. (A full copy of our privacy policy is available upon request).

I, _____ do consent to being assessed and treated by York-med Physiotherapy and wellness Centre. I hereby authorize the release of my assessment or progress notes or any other medical information to my:

□ Family Doctor/Specialist □ Legal representative □ Workers Compensation Board □Employer Representative

Initial _____ (above section read)

Payment Policy/ Cancellation and no-show fee policy

- Payment is due on the service date, right after your treatment session. We accept cash, debit, cheque, and all major credit cards as payment for service rendered.
- I understand that payment for services received at York-Med Physiotherapy & wellness center are my responsibility. If my claim is to be submitted directly to an outside agency for payment, and for some reason the third-party payer, such as insurance or employer, denies the claim and/or refuses to pay all or any of the full amount billed, I am responsible to pay the outstanding amount.
- In York-med Physiotherapy we reserve the right to refer any patient to the collection if they refuse to pay their balance in their account or any compliance with policy.
- Appointments must be cancelled 24 hours in advance of your scheduled appointments. We know life could be busy and would be unexpected, therefore first reasonable cancellation is on us, but second cancellation will be charged 50% of the original service.
- Please be advised that your insurance will not cover any charges for no show fees.\
- Your signature below indicated you have understood and have reviewed out no show fee policy.

- I have read the above information and indicate my consent. **Initial _____ (above section read)**

AUTHORIZATION FOR SUBMISSION & DIRECT PAYMENT

(If you need us to submit on behalf of you)

Insurance company name _____

Policy # _____ ID/Cert #_____

Policy holder name _____ Date of Birth _____

I, _____, hereby authorize York-med Physiotherapy &wellness Centre to submit to my health care benefits on my behalf, and assign the payment for my health care benefits, as per the enclosed invoice, directly to York-Med physiotherapy & wellness Centre. As an EHC client, should any submitted claims deem unpayable, I agree that I will be held responsible to pay any outstanding balance for services rendered with the York-med Physiotherapy wellness Centre. Please be advised the authorization form for submission & direct payment will be valid until discharge and all accounts have been cleared. I have read and understand. **Initial _____ (above section read)**

CONSENT TO CHIROPRACTIC TREATMENT

It is important for you to consider the benefits, risks and alternatives to the treatment options offered by your chiropractor and to make an informed about proceeding with treatment.

Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body, soft-tissue techniques such as massage, and other forms of therapy including, but not limited to, electrical light therapy and exercise.

Benefits

Chiropractic treatment has been demonstrated to be effective for complaints of the neck, back and other areas of the body caused by nerves, muscles, joints and related tissues. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility, improve function, and reduce or eliminate the need for drugs and surgery.

Risks

The risks associated with chiropractic treatment vary according to each patient's condition as well as the location and type of treatment.

The risks include:

- **Temporary worsening of symptoms**- Usually, any increase in pre-existing symptoms of pain or stiffness will last only a few hours to a few days.
- **Skin irritation or burn** – Skin irritation or a burn may occur in association with the use of some types of electrical or light therapy. Skin irritation should resolve quickly. A burn may leave a permanent scar.
- **Sprain or strain** – Typically, a muscle or ligament sprain or strain will resolve itself within a few days or weeks with some rest, protection of the area affected and other minor care.
- **Rib fracture** – While a rib fracture is painful and can limit your activity for a period of time, it will generally heal on its own over a period of several weeks without further treatment or surgical intervention.
- **Injury or aggravation of a disc** – Over the course of a lifetime, spinal discs may degenerate or become damaged. A disc can degenerate with aging, while disc damage can occur with common daily activities such as bending of lifting. Patients who already have a degenerated damaged disc may or may not have symptoms. They may not know they have a problem with a disc. They also may not know their disc condition is worsening because they only experience back or neck problems once in a while.

  Chiropractic treatment should not damage a disc that is not already degenerated or damaged, but if there is a pre-existing disc condition, chiropractic treatment, like many common daily activities, may aggravate the disc condition.

  The consequences of disc injury or aggravating a pre-existing disc condition with vary with each patient. In the most severe cases, patient symptoms may include impaired back or neck mobility, radiating pain and numbness into the legs and arms, impaired bowel or bladder function, or impaired leg or arm function. Surgery may be needed.

- **Stroke** – Blood flows to the brain through two sets of arteries passing through the neck. These arteries may become weakened and damaged, either over time through the neck. These arteries may become weakened and damaged, either over time through ageing or disease, or as a result of injury. A blood clot may form in a damaged artery. All or part of the clot may break off and travel up the artery to the brain where it can interrupt blood flow and cause a stroke.

310-250 Harding Blvd, Richmond Hill, ON. TEL: 905-737-1928 FAX: 905-7376178

Many common activities of daily living involving ordinary neck movements have been associated with stroke resulting from damage to an artery in the neck, or a clot that already existed in the artery breaking off and travelling up to the brain.

Chiropractic treatment has also been associated with stroke. However, that association occurs very infrequently, and may be explained because an artery was already damaged and the patient was progressing toward a stroke when the patient consulted the chiropractor. Present medical and scientific evidence does not establish the chiropractic treatment causes either damage to an artery or stroke.

The consequences of a stroke can be very serious, including significant impairment of vision, speech, balance and brain function, as well as paralysis or death.

Alternatives

Alternatives to chiropractic treatment may include consulting other health professionals. Your chiropractor may also prescribe rest without treatment, or exercise with or without treatment.

Questions or concerns

You are encouraged to ask questions at any time regarding your assessment and treatment. Bring any concerns you have to the chiropractor's attention. If you are not compatible, you may stop treatment at any time.

Please be involved in and responsible for your care. Inform your chiropractor immediately of any change in your condition.

DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR

I hereby acknowledge that I have discussed with the chiropractor the assessment of my condition and the treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I hereby consent chiropractic treatment as proposed to me.

_____
Name (Please Print)

_____ Date:_____20_____
Signature of patient (or legal guardian)

_____ Date:_____20_____
Signature of Chiropractor

310-250 Harding Blvd, Richmond Hill, ON. TEL: 905-737-1928 FAX: 905-7376178

Release of Liability, Waiver of all Possible Claims and Assumption of Risk

Please review before signing

I, _____ hereby acknowledge that I have agreed to meet with **Katherine Siu** at **York-Med Physiotherapy & Wellness Centre** for the purpose of receiving **Chiropractic treatment**.

I acknowledge and accept that there is a risk that I could be exposed to COVID-19 while attending at the Facility. I also acknowledge and accept that while receiving services, the HCP may need to be closer than the recommended social distancing guidelines in order to assess and/or treat me. I acknowledge and confirm that I am willing to accept this risk as a condition of attending at the Facility to receive services from the HCP.

In consideration of the HCP agreeing to see me in person at the Facility, I agree to release the HCP and the Facility (if applicable), their officers, directors, employees, agents and volunteers (the "Releasees") from any and all causes of action, claims, demands, requests, damages or any recourse whatsoever in respect of any personal injuries or other damages which may occur or arise as a result of exposure to COVID-19 during my visit to the Facility and/or through the provision of services to me by the HCP.

I do hereby acknowledge and agree that notwithstanding the generality of the foregoing, I declare that I will not commence litigation or otherwise seek to recover damages or other compensation against the Releasees based on any action, claim, demand, request, loss or any recourse whatsoever arising from any potential or actual exposure to COVID-19 while attending at the Facility and/or through the provision of services to me by the HCP.I further acknowledge that the Releasees can rely on this Release of Liability, Waiver of all Possible Claims and Assumption of Risk as a complete defence to any and all claims, damages, causes of action, or recourse or liability that may arise at any time.

I have carefully reviewed this Release of Liability, Waiver of all Possible Claims and Assumption of Risk and acknowledge that I fully understand the terms as set out above. I acknowledge that I am signing this Release of Liability, Waiver of all Possible Claims and Assumption of Risk voluntarily.

_____ _____

Signature of patient Date

TELUS Health

Electronic transmission authorization and consent form

Instructions: This form must be filled out when claims are submitted electronically by the provider on the patient's behalf. Please retain this form in the patient's file for verification purposes for two years following closure of the patient file.

Provider		
First and last name or clinic name: York-Med Physiotherapy & Wellness Center		
Address: 250 Harding Blvd W., Suite 310		
City: Richmond Hill	Province: ON	Postal code: L4C 9M7

Patient	
First name	Last name
Primary coverage insurer/payer	Primary coverage plan member name
Primary coverage policy number (also referred to as group or contract number)	
Primary coverage certificate (also referred to as member/identification number)	
(Canada Life only) secondary coverage plan member name	

Consent to collect and exchange personal information

Purpose

Personal information that we collect and disclose about you, and if applicable, is used by the insurer, and/or plan administrator of your group benefits plan, its affiliates and their service provider(s) for the purposes of assessing eligibility for your claims, underwriting, investigating, auditing and otherwise administering the group benefits plan, including the investigation of fraud and / or plan abuse and for internal data management and data analytical purposes.

Authorization and consent

I authorize my healthcare provider to collect, use and disclose personal information concerning any claims submitted on my behalf with the insurer and/or plan administrator and their service provider(s) for the above purposes.

I authorize such insurer and / or plan administrator and their service provider(s) to:

- use my personal information for the above purposes.
- exchange personal information with any individual or organization, including healthcare professionals, investigative agencies, insurers and reinsurers, and administrators of government benefits, or other benefits programs, other organizations, or service providers working with such insurer and/or plan administrator or any of the foregoing, when relevant for the above purposes.
- where applicable exchange personal information concerning any claims with any assignee of benefits payable and exchange personal information for the above purposes electronically or in any other manner.

I understand that personal information may be subject to disclosure to those authorized under applicable law.

I agree that a photocopy or electronic version of this authorization shall be as valid as the original, and may remain in effect for the continued administration of the group benefits plan.

In the event there is suspicion and/or evidence of fraud and/or plan abuse concerning any 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 employer or benefit plan sponsor, for the purposes of investigation and prevention of fraud and/or benefit plan abuse. I understand that the submission of fraudulent claims is a criminal offence.

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 benefit plan sponsor, for that purpose.

If the patient is a person other than myself, I confirm that the patient has given their consent to provide their personal information for the healthcare provider and the insurer and/or plan administrator and their service provider(s) to use and disclose their personal information as set out above.

☐ **I accept the terms and conditions**

Benefit assignment form

I hereby assign benefits payable for the eligible claims to the healthcare provider responsible for submitting my claims electronically to the group benefits plan and I authorize the insurer/plan administrator to issue payment directly to such provider. In the event my claim(s) are declined by the insurer/plan administrator, I understand that I remain responsible for payment to the healthcare provider for any services rendered and/ or supplies provided.

I acknowledge and agree that the insurer/plan administrator is under no obligation to accept this benefit assignment form, that any benefit payment made in accordance with this benefit assignment form will discharge the insurer/plan administrator of its obligations with respect to that benefit payment, and that in the event the benefit payment is made to me, the insurer/plan administrator will also be discharged of its obligation with respect to that benefit payment.

I understand that this assignment will apply to all eligible claims submitted electronically by my healthcare 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 healthcare provider.

☐ **I accept the terms and conditions**

_____ _____

Date Signature of plan member

All information contained herein is protected by privacy laws including the Personal Information Protection and Electronic Documents Act (PIPEDA) and all the corresponding provincial legislation. All users agree to protect the personal health information contained herein from unauthorized use, disclosure, loss, theft, or compromise in accordance with the above noted laws and with at least the same care employed to protect their own confidential information. Any unauthorized access, disclosure or use of this information is illegal.

YORK MED PHYSIO

PATIENT: _____ **CHIROPRACTIC INITIAL ASSESSMENT** DATE: _____

SPINAL PALPATION		
L		R
	C0	
	C1	
	C2	
	C3	
	C4	
	C5	
	C6	
	C7	
	T1	
	T2	
	T3	
	T4	
	T5	
	T6	
	T7	
	T8	
	T9	
	T10	
	T11	
	T12	
	L1	
	L2	
	L3	
	L4	
	L5	
	SI	

RANGE OF MOTION

	CERVICAL					THORACIC					LUMBAR				
	0%	25%	50%	75%	100%	0%	25%	50%	75%	100%	0%	25%	50%	75%	100%
Flexion															
Extension															
R – Lat Flex															
L – Lat Flex															
R – Rotation															
L – Rotation															

SOFT TISSUE PALPATION

	CERVICAL					THORACIC					LUMBAR				
	HT R	HT L	SP R	SP L		HT R	HT L	SP R	SP L		HT R	HT L	SP R	SP L	
Upper Traps					Mid / Low Traps					Erectors					
Splenius Capitus					Rhomboids					QL					
Suboccipital					Erectors T1-T4					Psoas					
Levator Scap					Erectors T5-T9					ITB / TFL					
SCM					Erectors T10-L2					Piriformis					
Masseters					Latissimus					Hamstrings					

SPINAL ORTHOPEDIC TESTS

C/S	L	R	L/S	L	R	SI	L	R
Valsalva			Trendelberg			Gaenslen		
Houles			Valsalva			Thigh Thrust		
Jackson's			Kemps			Iliac comp		
Compression			SLR			PA PSIS		
Kemps			Braggards					
Soto Hall			Bowstrings					
Shoulder Depression			Thomas					
Brudzinski			Fabere					
			Gaenslen					
T/S			Maignes					
Sternal Compression			Yeoman					

L	CN TESTS-CEREBRAL TEST	R
	Cranial Nerve 2-12	
	Rhomberg's/Pronator Drift	
	Heel Toe Walking	
	Rapid Alt. Mvts	
	Finger to Nose	

NEUROLOGICAL TESTING

	Sensory S/D			Motor X/5			DTR	
C4								
C5								
C6								
C7								
C8							0=no response	
T1							1+=low	
L1							2+=average	
L2							3+=Brisker	
L3							4+=VBrsk,clonus	
L4								
L5								
S1								
S2								

NOTES:

CHIROPRACTIC SUBJECTIVE REPORT

Patient Name: _____ **Date of Evaluation:** _____

HEADACHES	VAS: / 10 Improvement Worse No Change
Location	Frontal R / L Occipital Eyes
Frequency	Constant Frequent Occasional
Description	dull aching sharp pulling tight tingling throbbing other _____
Aggravation	Noise Light other _____
Relief	Rest heat cold therapy meds nothing other _____

NECK / UPPER BACK	VAS: / 10 Improvement Worse No Change
Location	Left Right Anterior Posterior Lateral Medial Inferior Superior
Frequency	Constant Frequent Occasional
Description	dull aching sharp pulling tight tingling throbbing other _____
Aggravation	flexion extension L / R rotation L / R lateral flexion sitting standing stooping walking sleeping reaching lifting carrying pushing pulling other _____
Relief	Rest heat cold therapy meds nothing other _____
Radiating	R / L Shoulder R / L Upper arm R / L Lower arm R / L Hands & Fingers Other: _____

MID BACK	VAS: / 10 Improvement Worse No Change
Location	Left Right Anterior Posterior Lateral Medial Inferior Superior
Frequency	Constant Frequent Occasional
Description	dull aching sharp pulling tight tingling throbbing other _____
Aggravation	flexion extension L / R rotation L / R lateral flexion sitting standing stooping walking sleeping reaching lifting carrying pushing pulling bending squatting kneeling rise from sit ascend stairs descend stairs other _____
Relief	Rest heat cold therapy meds nothing other _____

LOW BACK	VAS: / 10 Improvement Worse No Change
Location	Left Right Anterior Posterior Lateral Medial Inferior Superior
Frequency	Constant Frequent Occasional
Description	dull aching sharp pulling tight tingling throbbing other _____
Aggravation	Lumbar flexion extension L / R rotation L / R lateral flexion Hip L / R flexion L / R extension L / R adduction L / R abduction L/ R INT rotation L/ R EXT rotation sitting standing stooping walking sleeping reaching lifting carrying pushing pulling bending squatting kneeling rise from sit ascend stairs descend stairs other _____
Relief	Rest heat cold therapy meds nothing other _____
Radiating	Pain radiates to: R / L Buttocks R / L Upper leg R / L Lower leg R / L Foot & Toes Other: _____

COMMENTS

NERVOUSNESS / ANXIETY: YES / NO SLEEP DIFFICULTIES : YES / NO

I hereby certify that I have read and understand the information recorded and verify that it is true and accurate. _____