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)

How did you hear about us? Google □ Our website □ Doctor Referrals □ Word of mouth □ Other _____

Did you have any related Pervious Injuries /Surgery? _____

Do 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 PHYSIOTEHRAPY ASSESSMENT/TREATMENT

Physiotherapy treatments may include techniques like **joint mobilizations, manipulations, diverse soft tissue release techniques, therapeutic exercise, and education, along with electrotherapy-related modalities such as ultrasound and IFC.** The response to treatment varies and cannot always be predicted as every individual is different. **Your recovery is our priority, and you will be informed in every step of your assessment and treatment.** The therapist will explain your diagnosis and discuss treatment recommendations and gives you alternative options if needed. At any time if you have any questions regarding treatment and services provided, please do not hesitate to talk to your therapist. Physiotherapy may include different types of physical evaluation and treatment and like any other forms of medical intervention; there are benefits and possible risks involved in the process.

Every effort is made to preserve modesty and keep you comfortable. During your physiotherapy visit, it is often necessary to expose and touch the area in need of assessment/treatment. If you do not feel comfortable with any part of the assessment/treatment, please tell us immediately. By signing this, I hereby consent to the rendering of a physiotherapy evaluation and treatment as deemed appropriate by the treating therapist. I understand that I have the right to decline treatment at any time. The therapist will explain my physiotherapy diagnosis and discuss treatment recommendations. I acknowledge my Physiotherapist has given me information that is pertinent to my assessment and treatment, including the possible risks and side effects of the proposed treatment and the alternative options. **I understand that my treatment may be administrated by the treating professional and by support staff under the supervision of the treating professional.**

I will immediately notify the Physiotherapist of any changes in my medical status. I will have the opportunity to discuss with my Physiotherapist the nature and purposes of all my proposed assessments and treatments. I am aware that I may withdraw this consent and discontinue treatment at any time.

Consent to Physiotherapy Assessment, Treatment, Disclosing Personal information, Payment Policy, Submission and Direct Payment and

Name of patient_____ Signature of patient_____ Date_____

Name of Physiotherapist_____ Signature of Physiotherapist_____ Date_____

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 **Mehran Moghaddasi** at **York-Med Physiotherapy & Wellness Centre** for the purpose of receiving **Physiotherapy 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

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.
- have 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.