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_____