YOUR HEALTH

Wellness Centre

200-1158 Winston Churchill Blvd
Oakville, ON L6J 0A3

Physical Therapy & Osteopathy New Patient Form

Patient Information (please print clearly)

Name: _____ Date of Birth: mm/dd/yyyy ____/____/_____ Age: _____

Address: _____ City: _____ Postal Code: _____

Phone: (H) _____ (B)_____ (M)_____

Email: _____ (to receive appointment reminders)

□ Add me to the email newsletter (Our newsletter covers events at the clinic and highlights informative articles written by our therapists. You can unsubscribe from the newsletter at any time.)

Occupation: _____ How did you find out about us? _____

Emergency Contact: (Name) _____ (Relationship) _____ (Phone number) _____

Billing Information

Is your complaint related to a motor vehicle accident? □ Yes □ No
If Yes, please fill in the following:

Date of accident: _____ Insurer's name: _____

Claim Number: _____ Insurer's address and telephone number: _____

Is your complaint a WSIB claim? □ Yes □ No
If Yes, please fill in the following:

Employer Name:_____ Social Insurance Number:_____

Employer address and telephone number: _____

Date of accident: _____ WSIB Claim Number: _____

Fee Schedule

Initial Assessment Physical Therapy: $95
Osteopathic Manual Medicine Initial Assessment: $95
Physical Therapy Regular Visit (approx. 30 mins): $75
Osteopathic Manual Medicine Regular Visit: $75

Payment is due at the time services are rendered. For your convenience, we accept cash, cheque, debit, Visa and Mastercard. This policy applies to all of our patients. We understand that unusual circumstances may arise and that payment in full at the time of service may not always be possible. Special payment needs should be discussed by the patient and a member of the business department. Payment plans are subject to approval by the administrator and your therapist. In such cases, you will receive a monthly statement showing all charges and payments. If you have not made payment in full, or made full financial arrangements with our office, your account will be reviewed for collection. If payment is not made on a bill from our office within forty-five (45) days after the date of the bill, interest may be charged to you on the balance of such bill commencing on the forty-fifth (45) day after the date of the bill. The interest rate will be eighteen percent (18%) per annum. Patients having health care coverage should remember that professional services provided are the patient's responsibility, not the insurance company. Our office does not file insurance claims for you; however, we would be happy to help you find the necessary documents and invoices upon complete payment of services for you to submit for reimbursement.

We require 24 hours notice if you are unable to make your scheduled appointment. After an initial warning, appointments cancelled with less than 24 hours notice will be charged in full, unless the appointment is rescheduled within 48 hours.

If you have any further questions regarding insurance, be certain to bring in your insurance book so we can determine your coverage and avoid confusion. We want your experience with YOUR HEALTH to be a pleasant one and we hope this information will help to make it so.

I have read the Your Health Wellness Centre financial policy and understand my financial responsibility and agree to the terms stated in the Financial Policy. I HEREBY AGREE TO PAY ANY AND ALL CHARGES FOR SERVICES RENDERED AND ITEMS PURCHASED AT YOUR HEALTH WELLNESS CENTRE.

Patient Signature: _____ Date: _____

Patient Name: _____ ___ Date: _____

Health History

Medical Doctor: _____Phone:_____

Previous Physical Therapy/Osteopathic care: (Name) _____(Phone Number)_____

Current Medications (including vitamins and supplements):

Previous fractures, surgeries, or hospitalizations (Please list and date):

List any medical problems that other doctors have diagnosed: _____

_____

List other current therapies (ie: chiropractic, massage):_____

Exercise level:
- □ Sedentary (no exercise)
- □ Mild exercise (e.g. Climb stairs, walk 3 blocks, golf)
- □ Occasional exercise (e.g. work or recreation less than 4x/week for 30 min)
- □ Regular vigorous exercise (e.g. work or recreation 4x/week or more for 30 min)

For Women Only:

Age of onset of menstruation: _____ Date of last menstruation: _____ Length of cycle: _____

Heavy periods, irregularity, spotting, pain or discharge?	□ Yes	□ No
Are you pregnant or breast-feeding?	□ Yes	□ No
Have you had a D&C, hysterectomy, or Cesaerean section?	□ Yes	□ No
Any urinary tract, bladder, or kidney infections in the past year?	□ Yes	□ No
Any blood in your urine?	□ Yes	□ No
Any problems with control or urination?	□ Yes	□ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	□ Yes	□ No

Date of last pap smear and rectal exam: _____

For Men Only:

Do you usually urinate during the night? □ Yes □ No If Yes, number of times: _____

Any blood in your urine?	□ Yes	□ No
Have you had any kidney, bladder, or prostate infections in the last 12 months?	□ Yes	□ No
Do you have any problems emptying your bladder completely?	□ Yes	□ No
Any testicle pain or swelling?	□ Yes	□ No

Date of last prostate and rectal exam: _____

Other Problems:

□ Skin □ Head/Neck □ Eyes □ Ears □ Nose □ Throat □ Lungs □ Chest/Heart	□ Back □ Intestines □ Bladder □ Bowels □ Circulation *Recent Changes in:* □ Weight □ Energy level □ Sleep Patterns	*Other areas of pain/discomfort:*

YOUR HEALTH

Wellness Centre

200-1158 Winston Churchill Blvd
Oakville, ON L6J 0A3

Privacy Policy

Privacy of personal information is important to YOUR HEALTH. We are committed to the collection, use and disclosure of this information in a responsible way. We will also try to be an open and transparent as to how we handle personal information.

Personal Information

Personal information is information about an identifiable individual. Generally, the information we collect is limited to your name, home contact information, gender, and age. As part of your patient file we retain your health history; health measurements and examination results; health conditions, assessment results and diagnoses; health services provided to you or received by you; your prognosis and other opinions formed; compliance with treatment; and the reasons for your discharge and discharge recommendations. We also maintain records for payment and billing purposes. Only necessary information is collected about you. We only share your information with your consent; the use, retention and privacy protection protocols. Privacy protocols comply with the privacy legislation, standards of our regulatory body, the College of Physiotherapists of Ontario and the law and/or The Ontario Osteopathic Association.

Staff Members

Staff members who come into contact with your personal information are aware of the sensitive nature of the information you have disclosed to us. They are all trained in the appropriate uses and protection of your information. These individuals include the clinic records personnel that control access to your patient file, therapists, clinic administration, and, when necessary, authorized individuals who may inspect our records as part of the regulatory activities in the public interest.

Disclosure of Personal Information

Our clinic understands the importance of protecting your personal information. To help you understand how we are doing that, we outline below how our clinics use and disclose this information:

- To deliver safe and effective patient care
- To enable us to contact you
- To communicate with other health care providers
- For teaching and demonstrating on an anonymous basis
- To complete and submit claims on your behalf to third party payers
- To comply, where appropriate with legal and regulatory requirements under the Physical Therapy Act and the Regulated Health Professions Act
- To process payments and collect unpaid accounts
- For research purposes

Please do not hesitate to discuss our privacy policy with any member of our clinic staff.

By signing the consent section of this form, you have agreed that you have given your informed consent to the collection, use, and/or disclosure of your personal information for the purposes that are listed. If a new purpose arises for the use and/or disclosure of your personal information, we will seek your approval in advance.

Patient Consent

I have reviewed the above information that explains how our clinic will use my personal information.

I agree that Your Health Wellness Centre can collect, use, and disclose my personal information as set out above in the College's privacy code.

_____
(Signature)

_____
(Print name)

_____
(Date)

_____
(Signature of Witness)

YOUR HEALTH

Wellness Centre

200-1158 Winston Churchill Blvd
Oakville, ON L6J 0A3

Informed Consent to Physical Therapy Treatment

Physical Therapists, who use manual therapy techniques such as Muscle Release Techniques, Soft Tissue Tools, and Therapeutic Stretching, are required to advise patients that there are some risks associated with such treatment procedures. In particular you should note:

While rare, some patients may experience short term aggravation of symptoms, redness, bruising, or muscle and ligament soreness as a result of manual therapy techniques

Instrument Assisted Soft Tissue Techniques and Myofacial Release Techniques used in our office are types of cross fiber or transverse friction massage. They are a form of treatment used to "break up" or "soften" scar tissue, thus allowing for the return of normal function in the area being treated. Treatment may produce the following symptoms: local discomfort during the treatment, reddening of the skin, superficial tissue bruising, or post treatment soreness. These techniques are designed to minimize discomfort; however the above reactions are normal, and in some instances unavoidable.

I acknowledge I have discussed, or have had the opportunity to discuss, with my physical therapist the nature and purpose of physical therapy treatment in general and my treatment in particular as well as the contents of this Consent. I consent to the physical therapy treatments offered or recommended to me by my physical therapist. I intend this consent to apply to all my present and future chiropractic care.

Dated this _____ day of _____, 20_____

Name: (print) _____ (Signature) _____

Witness: (print) _____ (Signature) _____

Informed consent to Classical Osteopathic Manual Medicine

I hereby request and consent to the performance of Classical Osteopathic Manual Medicine and other procedures related to manual and other techniques within the scope of practice of manual osteopathic medicine.

I have had the opportunity to discuss with the manual osteopath and/or with other office or clinic personnel the nature and purpose of manual osteopathic medical care and other procedures. I understand that the results are not guaranteed.

I understand and am informed that, as with all health care, the practice of manual osteopathy possesses slight risks from treatment, including, but not limited to, temporary soreness, bruising, nausea, light-headedness, fatigue & changes in bowel/bladder function. I do not expect the manual osteopath to anticipate and explain all the risks and complications and I wish to rely on the practictioner to exercise judgment during the course of the procedure which the she feels at the time, based upon the facts then known, are in my best interest.

I have read the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above named procedures(s). I intent this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Dated this _____ day of _____, 20_____

Name: (print) _____ (Signature) _____

Witness: (print) _____ (Signature) _____