YOUR HEALTH

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

Reiki - 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) _____

Fee Schedule

30 minute treatment: $45.00 60 minute treatment: $70.00 90 minute treatment: $100.00

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: _____

Consent for Treatment for Reiki

I understand and accept that the reiki session given is for the purpose of stress reduction, relaxation, and therapeutic value only. I understand very clearly that a reiki session is not a substitute for medical, psychological diagnosis and treatment. Reiki practitioners do not diagnose conditions, nor do they prescribe medical treatment or supplements, nor interfere with the treatment of a licensed medical professional. It is recommended that I see a licensed health care professional for any physical/psychological ailment I have.

Signature:_____ **Date:**_____

(parent/guardian if under 18 years)

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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 Chiropractors of Ontario and the law.

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 with legal and regulatory requirements under the Chiropractic 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 of parent/guardian)

_____
(Print name)

_____
(Date)

_____
(Signature of Witness)

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History

Any Findings at last Medical Visit?
_____
_____
_____
_____
_____

Have you had Reiki before?
No ☐ Yes ☐

Any history of major illness?
No ☐ Yes ☐
Please Describe: _____
_____
_____

Any history of broken bones?
No ☐ Yes ☐
Please Describe: _____
_____
_____

Have you had any surgery?
No ☐ Yes ☐
Please Describe: _____
_____
_____

How is your blood pressure?
Normal ☐ Not Normal ☐
Please Describe: _____
_____
_____

Have you had any accidents?
No ☐ Yes ☐
What/When?_____
_____
_____
_____

Are you on any medication?
No ☐ Yes ☐
Please Describe: _____
_____
_____

Do you have any heart problems? No ☐ Yes ☐
Please Describe: _____
_____
_____

Do you have a pacemaker or any prostheses?
No ☐ Yes ☐
Please Describe: _____
_____
_____

Do you have any circulatory problems?
No ☐ Yes ☐
Please Describe: _____
_____
_____

Any history of cancer?
No ☐ Yes ☐
Please Describe: _____
_____
_____

Do you have diabetes?
No ☐ Yes ☐
Please Describe: _____
_____
_____

Are you trying any other therapies?
No ☐ Yes ☐
Please Describe: _____
_____
_____

Do you have any issues with sleeping?
No ☐ Yes ☐
Please Describe: _____
_____
_____
_____

Are you feeling stressed about any of the following?

Health (self) ☐
Health (others) ☐
Addictions (self) ☐
Addiction (others) ☐
Anxiety ☐
Depression ☐
Finances ☐
Career ☐
Partner ☐
Children ☐
Parents ☐
Siblings ☐
Employer ☐
Co-workers ☐

Are you stressed about anything else not listed?

Is there something specific that you would you like Reiki to resolve or help you with?

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Initial Assessment

Client Name: _____ **Date: _____**

Comments, Observations and Discussions:

Therapist Initials: _____