YOUR HEALTH

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

Physiotherapy 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 for clinic events and informative articles (You can unsubscribe at any time.)

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

Emergency Contact: (Name) _____

(Relationship) _____ (Phone number) _____

Is your complaint related to a motor vehicle or WSIB accident? [ ] Yes [ ] No

Medical Doctor: _____ Phone: _____

[ ] I consent to YOUR HEALTH communicating with my medical doctor regarding my treatment.

Date of last medical appointment and reason: _____

Previous Physiotherapy care: Name: _____ Phone_____

Current Symptoms

What is your main complaint? _____

_____

When did it start? _____

How often do you feel it? _____

Does it affect other areas of your body? To what areas does the pain radiate/shoot/travel?

_____

What makes the problem worse? (e.g. time of day, movements, certain activities)

_____

What lessens the problem? _____

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Fee Schedule

Initial Assessment: $100.00 Follow up Visit: $60.00

Follow up Visit with Laser: $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: _____

Patient Name: _____

Date: _____

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Patient Name: _____ *Date:* _____

HEALTH HISTORY

Current Medications (including vitamins and supplements):

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

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)

Other Conditions		
[ ] 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:

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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 Physiotherapists 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 Physiotherapy 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)	(Signature of Witness)
(Print name)	(Date)

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INFORMED CONSENT TO PHYSIOTHERAPY TREATMENT

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

I, undersigned, do hereby give my voluntary consent for the administration of Physiotherapy deemed appropriate by my treating Physiotherapist. I understand that Physiotherapy treatments may include an individualized exercise prescription and various forms of manual therapy techniques such as mobilization, manipulation, soft tissue release and stretches. Treatments may also include modalities such as heat, ice, therapeutic taping, ultrasound, laser, TENS and electric muscular stimulation. I understand that the primary goals of Physiotherapy treatments are to help reduce my pain and improve my mobility, strength, endurance, function and quality of life.

I understand that there are small possibilities of risks or complications that may result from the above listed treatments. I do not expect the Physiotherapist to anticipate all the possible risks and complications.

I wish to rely on the Physiotherapist to exercise proper judgment during the course of treatment to make decisions based upon my best interest. Potential small but possible risk factors:

Manual therapy: Joint and/or muscle soreness

Exercise therapy: Joint and/or muscle soreness

Electrical modalities: Minor skin irritations such as redness or rash

Therapeutic Taping: Minor skin irritations such as redness or rash

Alternatives
Alternatives to Physiotherapy treatment may include consulting other health professionals.

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

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

DO <u>NOT</u> SIGN THIS FORM UNTIL YOU MEET WITH THE PHYSIOTHERAPIST

I hereby acknowledge that I have discussed with the Physiotherapist 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 to physiotherapy treatment as proposed to me.

_____
Name (Please Print)

_____ Date: _____ 20____
Signature of patient (or legal guardian)

_____ Date: _____ 20____
Signature of Physiotherapist

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