

# PHYSIOSENSE

## Patient Information

Surname:		Given Name(s):	
Street Address:			
City:		Postal Code:	
Date of Birth: (mm/dd/yyyy) / /		Marital Status: Single / Married / CommonLaw / Divorced / Separated / Widowed	
Home Phone#:		Mobile Phone#:	
Gender: M ( ) F ( ) Other ( )		Email:	
Emergency Contact Name:	Relationship to you:	Emergency Contact Phone Number(s):	
		1)	2)
Family Physician:		Referring Physician (if applicable):	

## How did you choose PhysioSense?

<input type="checkbox"/> Family Physician	<input type="checkbox"/> Other Physician	<input type="checkbox"/> Insurance Company
<input type="checkbox"/> I am a Returning Patient	<input type="checkbox"/> Advertisement (please specify)	<input type="checkbox"/> Word of Mouth (please specify)
<input type="checkbox"/> Internet Search/Our Website	<input type="checkbox"/> Community Event (please specify)	<input type="checkbox"/> Social Media (please specify)
<input type="checkbox"/> Other (please specify):		<input type="checkbox"/> Convenient Location

## Employer Information ( check if retired or not employed )

Name of Employer:	
Occupation:	
Work Phone #:	Work Fax #:

## Private Insurance Information

Do you have private health insurance? Yes <input type="checkbox"/> No <input type="checkbox"/>	
If yes, please fill in the information below:	
<input type="checkbox"/> I prefer not to disclose my insurance information and will handle all claim submissions myself	
Insurance Company Name, Address:	
Phone#:	Fax#:
Policy#:	Group#:
I.D.#:	Plan#:
If you are covered under someone else's plan:	
Name of Insured:	D.O.B. of Insured: (mm/dd/yyyy) / /

# PHYSIOSENSE

## CONSENT AND AUTHORIZATION FOR THE RELEASE AND/OR COLLECTION OF MEDICAL INFORMATION AND DIAGNOSTIC MATERIAL

I do hereby give my written consent/authorization to PhysioSense (including health practitioners, support staff, administrative staff) to communicate on my behalf and to release and share information regarding my health and progress for the purposes of determining my functional abilities, developing and implementing my rehabilitation program, and assisting in the betterment of my overall health.

I understand that such communication and sharing of information may take place with, but is not limited to, the following: physicians and other health care professionals involved with my care; insurance company representatives; my employer (or representatives of my employer); my lawyer (or representatives of my lawyer).

I explicitly give permission to the following to provide and receive information pertaining to my medical/rehabilitative condition:

- Family Physician \_\_\_\_\_
- Insurance Company \_\_\_\_\_
- Employer \_\_\_\_\_
- Lawyer \_\_\_\_\_
- Other \_\_\_\_\_

This consent may be revoked in writing at any time. Any such revocation shall have no effect on disclosures made prior to the date of revocation. I understand that I have the right to inspect the information to be disclosed.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

# PHYSIOSENSE

## Patient Consent

### Consent for Assessment & Treatment

I give my consent to undergo assessment and treatment. I have had the chance to discuss with my healthcare provider(s) the risks and benefits for my particular condition. I have been educated about the potential benefits of the proposed treatment, alternative courses of action, and the consequences of not having the services proposed. I have been informed of the potential risks associated with physiotherapy treatment. They include, but are not limited to, increased discomfort or pain, burns from modalities, redness or other skin irritation, re-injury, muscle sprains and strains, and fractures. I agree to inform the therapist immediately of any concerns. I wish to rely on the clinician to exercise his/her best judgement during the course of all interventions, based upon the facts he/she then knows.

My clinician has responded to all my requests for other information about the services proposed. I understand that results are not guaranteed and that I may withdraw this consent at any time. I understand that some aspects of treatment may be assigned to, and carried out by, clinical support staff (e.g. kinesiologist, physiotherapy assistant, etc.). I acknowledge that PhysioSense contributes to the ongoing betterment of health care professions by acting as a teaching facility from time to time. In cases where it is deemed appropriate by my therapist, I agree to have a student carry out part of my assessment/treatment plan under supervision.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ Clinician Initials - Consent Confirmed After Assessment

### Use of Personal Information

I understand that PhysioSense collects, uses, discloses, retains and disposes of my personal information in compliance with federal and provincial privacy legislation and applicable college regulations. All staff members who come into contact with my personal information have been trained in the appropriate use and protection of my information. If I have any questions, I may inquire with my practitioner. I understand that PhysioSense uses and discloses my personal information in the following ways:

- To assess my health concerns, advise me of options and provide healthcare
- To communicate with health care providers or other parties involved in my health care
- To obtain/share diagnostic test results pertinent to my condition
- To establish and maintain contact with me
- To complete claims for insurance purposes
- To invoice for goods and services
- To collect unpaid accounts and process credit card payments
- To comply with the law
- To contact me from time to time about services, special offers, feedback, clinic updates and other opportunities

I would like to receive email reminders of my appointments

NB: email reminders are a courtesy provided by PhysioSense and any failure to receive them (due to technical malfunction or other) is not a valid reason for missing an appointment without proper notification.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# PHYSIOSENSE

## **Financial Responsibility**

### Fee Schedule

Physiotherapy/Chiropractic Initial Assessment	\$80
Subsequent physiotherapy session	\$60/\$40
Subsequent chiropractic session	\$60/\$40
Massage - 60min	\$85*
Massage- 45min	\$70*
Massage- 30min	\$55*

\*HST included

PhysioSense will bill your insurance carrier on your behalf when direct billing is possible.

In the following circumstances you will be responsible to pay at the time of service or product purchase:

- When you do not have any insurance that will cover the product or service
- When your insurance carrier sends payment directly to you or requires that you pay and submit your expenses
- When your coverage does not pay 100% or has been used up (you are responsible for the copayment)
- When a product is custom made (deposit is required before ordering)

In the following circumstances you can provide your credit card information and carry an outstanding balance:

- If you have an approved car insurance claim and your extended health benefits are paid to you directly (we will bill your credit card if the payment has been confirmed and it has remained outstanding for a period of 30 days) \*
- If you start treatment before getting approval for a car insurance or work injury claim (if your claim gets rejected, we will notify you and bill your credit card once the remaining balance is outstanding for a period of 30 days) \*

\*Please bring to the clinic copies of paperwork you receive from any of your insurance companies

I have reviewed the fee schedule and read and understand the above statements regarding financial responsibility.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **Cancellation Policy**

I acknowledge that 24 hours advance notice is required for any cancellations and that PhysioSense reserves the right to charge a cancellation fee if this is not adhered to.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# PHYSIOSENSE

## 2018 PAR-Q+

### The Physical Activity Readiness Questionnaire for Everyone

The health benefits of regular physical activity are clear; more people should engage in physical activity every day of the week. Participating in physical activity is very safe for MOST people. This questionnaire help to determine whether it is necessary for you to seek further advice from your doctor OR a qualified exercise professional before becoming more physically active.

#### GENERAL HEALTH QUESTIONS

Please read the 8 questions below carefully and answer each one honestly: check YES or NO.	YES	NO
1) Has your doctor ever said that you have a heart condition <input type="checkbox"/> OR high blood pressure <input type="checkbox"/> ?		
2) Do you feel pain in your chest at rest, during your daily activities of living, <b>OR</b> when you do physical activity?		
3) Do you lose balance because of dizziness <b>OR</b> have you lost consciousness in the last 12 months? Please answer <b>NO</b> if your dizziness was associated with over-breathing (including during vigorous exercise).		
4) Have you ever been diagnosed with another chronic medical condition (other than heart disease or high blood pressure)? <b>PLEASE LIST CONDITION(S) HERE:</b>		
5) Are you currently taking prescribed medications for a <u>chronic medical condition</u> ?		
6) Do you currently have (or have had within the past 12 months) a bone, joint, or soft tissue (muscle, ligament, or tendon) problem that could be made worse by becoming more physically active? Please answer <b>NO</b> if you had a problem in the past, but it does not limit your current ability to be physically active. <b>PLEASE LIST CONDITION(S) HERE:</b>		
7) Has your doctor ever said that you should only do medically supervised physical activity?		
8) Do you currently participate in any regular activity/program designed to improve or maintain your physical fitness? If yes, please indicate what type of activity/program:		

#### PARTICIPANT DECLARATION

If you are less than the legal age required for consent or require the assent of a care provider, your parent, guardian or care provider must sign this form. I, the undersigned, have read, understood to my full satisfaction and completed this questionnaire. I acknowledge that this physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if my condition changes. I also acknowledge that the PhysioSense may retain a copy of this form for records. In these instances, confidentiality will be maintained, complying with applicable law.

NAME \_\_\_\_\_

DATE \_\_\_\_\_

SIGNATURE \_\_\_\_\_  
(OR SIGNATURE OF PARENT/GUARDIAN/CARE PROVIDER)

# PHYSIOSENSE

It is very important for your practitioner(s) to have a clear picture of your current health and health history. Please indicate whether you currently have, or have ever had, the conditions listed below. If you aren't sure about something, leave it blank or indicate with a question mark (?). Your practitioner will review this with you.

Condition:	Yes	No	Condition:	Yes	No
Arthritis			High Cholesterol		
Diabetes			Gout		
Thyroid Dysfunction			Skin Conditions		
High Blood Pressure			Tape or Latex Allergy		
Low Blood Pressure			Memory Problems		
Heart Attack			Vision Impairment		
Angina (chest pain)			Hearing Impairment		
Pacemaker			Depression and/or Anxiety		
Other Heart Condition			Osteoporosis		
Cancer (current)			Dizziness, Vertigo, Fainting		
Cancer (previous)			Migraine Headaches		
Epilepsy/Other Seizure Disorder			Other Headaches		
Shortness of Breath			Raynaud's Disorder		
Asthma			Sleeping Problems		
Bronchitis or Chronic Cough			Loss of Balance/Falls		
Stroke			Smoking (past or current)		
Bleeding Disorder (haemophilia or other)			Metal Implants (pins, plates, wires, screws, joint replacements)		
Anemia			<i>Unexplained</i> Weight Loss/Gain		
Bowel and/or Bladder Difficulties			Numbness/Tingling		
Lower Back Pain			Hepatitis		
Neck Pain			HIV/AIDS		
Fibromyalgia			Multiple Sclerosis		
Chronic Fatigue Syndrome			Parkinson's Disease		
GERD (acid reflux)			Other Neurological Disease/Disorder		

**ADULT FEMALE PATIENTS: ARE YOU CURRENTLY PREGNANT? YES NO**

(Note: if you become pregnant whilst attending for treatment, it is imperative that you notify us immediately)

Please indicate any significant past **injuries** or **surgeries** (include specific or approximate dates) or **conditions**:

Current medications/supplements (if you have a list available, please present it to the administrator and we will copy it with your permission instead of listing them in this space):

Allergies:

I have completed this health history to the best of my knowledge:

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

# PHYSIOSENSE

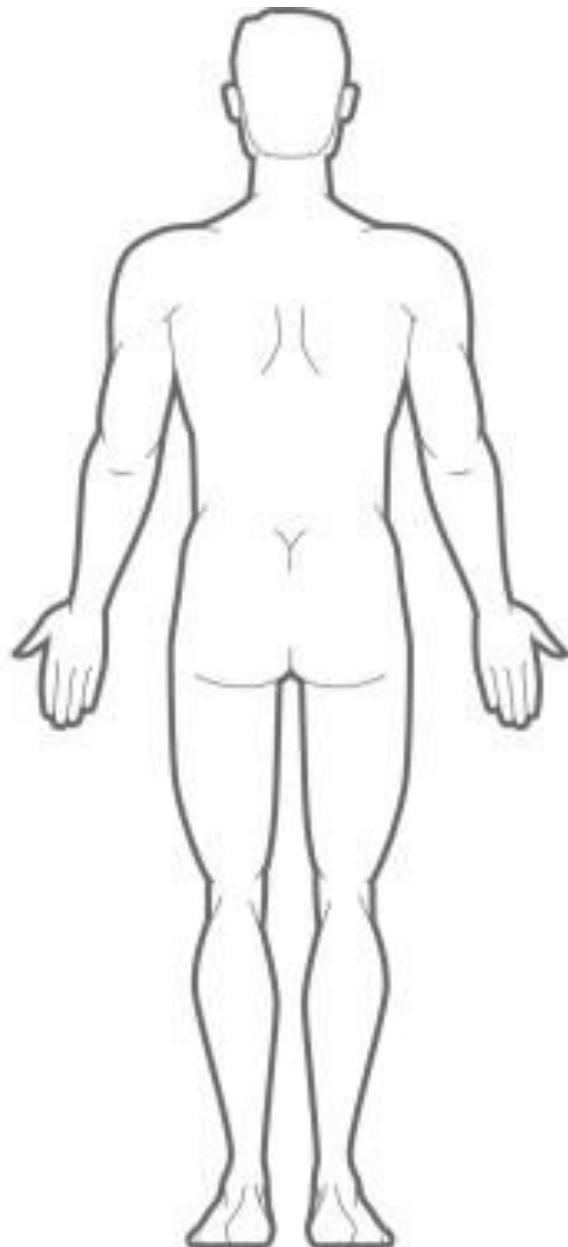
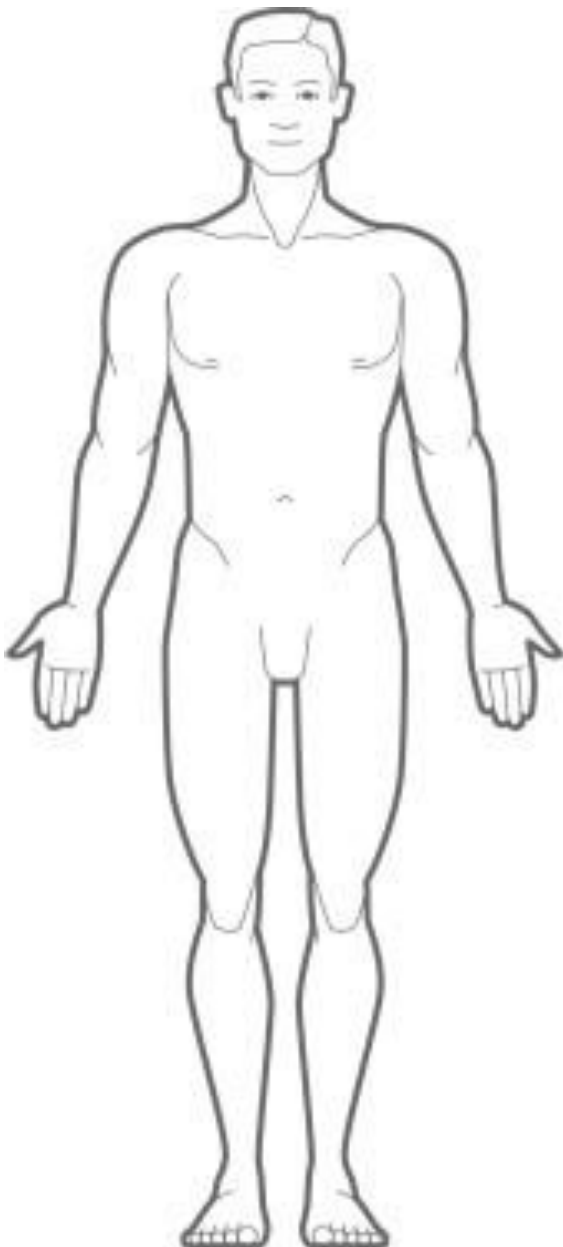
Please use the body diagrams below to show us where you are experiencing symptoms. You can use the indicated symbols or you can simply circle areas. Feel free to write words to describe the symptoms.

Achy Pain      XXXX

Sharp Pain    \*\*\*\*\*

Stiffness      /////

Numbness     oooo



# PHYSIOSENSE

## EXTENDED HEALTH COVERAGE – PLAN DETAILS

I prefer not to disclose my plan details (initial) \_\_\_\_\_

### Physiotherapy

Maximum per year: \_\_\_\_\_

Maximum per treatment: \_\_\_\_\_

Amount remaining: \_\_\_\_\_

Physician's Referral Required: YES / NO

### Massage Therapy

Maximum per year: \_\_\_\_\_

Maximum per treatment: \_\_\_\_\_

Amount remaining: \_\_\_\_\_

Physician's Referral Required: YES / NO

### Chiropractic

Maximum per year: \_\_\_\_\_

Maximum per treatment: \_\_\_\_\_

Amount remaining: \_\_\_\_\_

Physician's Referral Required: YES / NO

### Orthotics

Maximum per year: \_\_\_\_\_

Maximum per pair: \_\_\_\_\_

Amount remaining : \_\_\_\_\_

Physician's Referral Required: YES / NO

Dispensing practitioner(s):

### Compression Hosiery

Maximum per year: \_\_\_\_\_

Maximum per pair: \_\_\_\_\_

Amount remaining: \_\_\_\_\_

Physician's Referral Required: YES / NO



# PHYSIOSENSE

## MOTOR VEHICLE ACCIDENT INFORMATION

Date of Accident: (mm/dd/yyyy)		Accident Location:	
You were: <input type="checkbox"/> Driver <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Cyclist			
Were you wearing a seatbelt? <input type="checkbox"/> Yes <input type="checkbox"/> No		Did your airbag deploy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No Airbags	Was there a head impact? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
Brief description of accident:			
Did the police attend? <input type="checkbox"/> Yes <input type="checkbox"/> No		Did an ambulance attend? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you already received any treatment for this accident? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please indicate the facility:			
Your status: <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> Student <input type="checkbox"/> Homemaker <input type="checkbox"/> On Disability			
If employed: Did you miss any time from work because of the accident? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you currently back to work? <input type="checkbox"/> Yes <input type="checkbox"/> No	

## AUTOMOBILE INSURANCE INFORMATION

Name of Insurance Company:	
Insurance Company Address:	
Name of Adjuster:	
Phone number: (     )	Fax number: (     )
Claim number:	Policy number:
Name of Insured:	

## LEGAL REPRESENTATION INFORMATION

Name and Address of Law Firm:	
Name of Legal Representative:	
Phone number: (     )	Fax number: (     )

# PHYSIOSENSE

## MOTOR VEHICLE ACCIDENT PATIENTS – PLEASE READ

We at PhysioSense are sorry to learn that you have been involved in an automobile accident. We know that the process can be difficult and sometimes overwhelming, and we want to help you to get through it as quickly and easily as possible. Therefore, we've put together a list of a few things you should be aware of up front:

- If you haven't already received it, you will get a package in the mail from your insurance company called the "Accident Benefits Package" or "OCF1". Your insurer requires you to complete all relevant forms in this package and return them within 30 days. It is **very** important that you do this. If you don't, you can expect some delays in your claim being processed, as well as delays in your treatment. Do not hesitate to ask us for assistance if you're not sure about some of the forms. Additionally, please provide us with a copy of this package so that we can answer any questions your insurer may have. This will make the process much easier for you.
- If you are covered by any extended health benefit plan (e.g. through work, or your own private coverage) you **must, by law**, provide it to us in order to properly handle your claim. Any such benefits will be exhausted prior to your automobile insurer commencing payment. We know that this is extremely frustrating for some of you. Please understand that this is not by choice of PhysioSense, but dictated by provincial law.
- If you have private insurance, we may ask you to pre-sign some claim forms. This will ensure that we are able to submit to your insurance company in a timely fashion (usually twice per month). If payment from your insurance company is sent directly to you (either by mail or direct deposit) following submission, you will be responsible for bringing it to our administrator as soon as possible.
- It's very easy to stick to these points, and by doing so it is highly unlikely that you will ever be responsible for out of pocket expenses related to your treatment. However, failure to adhere to these points may result in an outstanding balance on your account.

Please remember that we are here to help. Don't hesitate to ask questions. We want to get you back to 100% as soon as possible!

I acknowledge that I have read and understand the above statements:

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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## IRREVOCABLE DIRECTION AND AUTHORIZATION (MVA)

I understand that PhysioSense will submit invoices to my insurance company related to the treatment I have received. I agree to provide PhysioSense with all necessary insurance documents and information.

I hereby irrevocably direct my insurer to make all payments for treatments received by me to PhysioSense and this shall be its good and sufficient authority to do so.

I agree that in the event that my insurer remits payments for such treatments directly to me, I shall forward such payments immediately to PhysioSense. In this regard, I understand that I will be personally responsible to remit the payment to PhysioSense.

In the event that my insurer should refuse to make payments for my treatments, I agree that PhysioSense shall have the right, in my name and on my behalf, to take whatever legal proceeding it deems necessary to collect payment for such treatments. I agree to fully cooperate with PhysioSense to provide any required documents and to attend at my mediation or arbitration hearings as would be necessary.

In the event I should refuse to cooperate as noted, I shall pay to PhysioSense the costs of such treatment, as well as any costs related to required legal proceedings, mediations, or arbitrations.

Patient Name: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_