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?

☐ Family Physician	☐ Other Physician	☐ Insurance Company
☐ I am a Returning Patient	☐ Advertisement (please specify)	☐ Word of Mouth (please specify)
☐ Internet Search/ Our Website	☐ Community Event (please specify)	☐ Social Media (please specify)
☐ Other (please specify):		☐ 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 ☐	No ☐
If yes, please fill in the information below:	
☐ 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 ☐ OR high blood pressure ☐ ?		
2) Do you feel pain in your chest at rest, during your daily activities of living, **OR** when you do physical activity?		
3) Do you lose balance because of dizziness **OR** have you lost consciousness in the last 12 months? Please answer **NO** 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)? **PLEASE LIST CONDITION(S) HERE:**		
5) Are you currently taking prescribed medications for a chronic medical condition?		
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 **NO** if you had a problem in the past, but it does not limit your current ability to be physically active. **PLEASE LIST CONDITION(S) HERE:**		
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)

PHYSI SENSE

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			*Unexplained* 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:

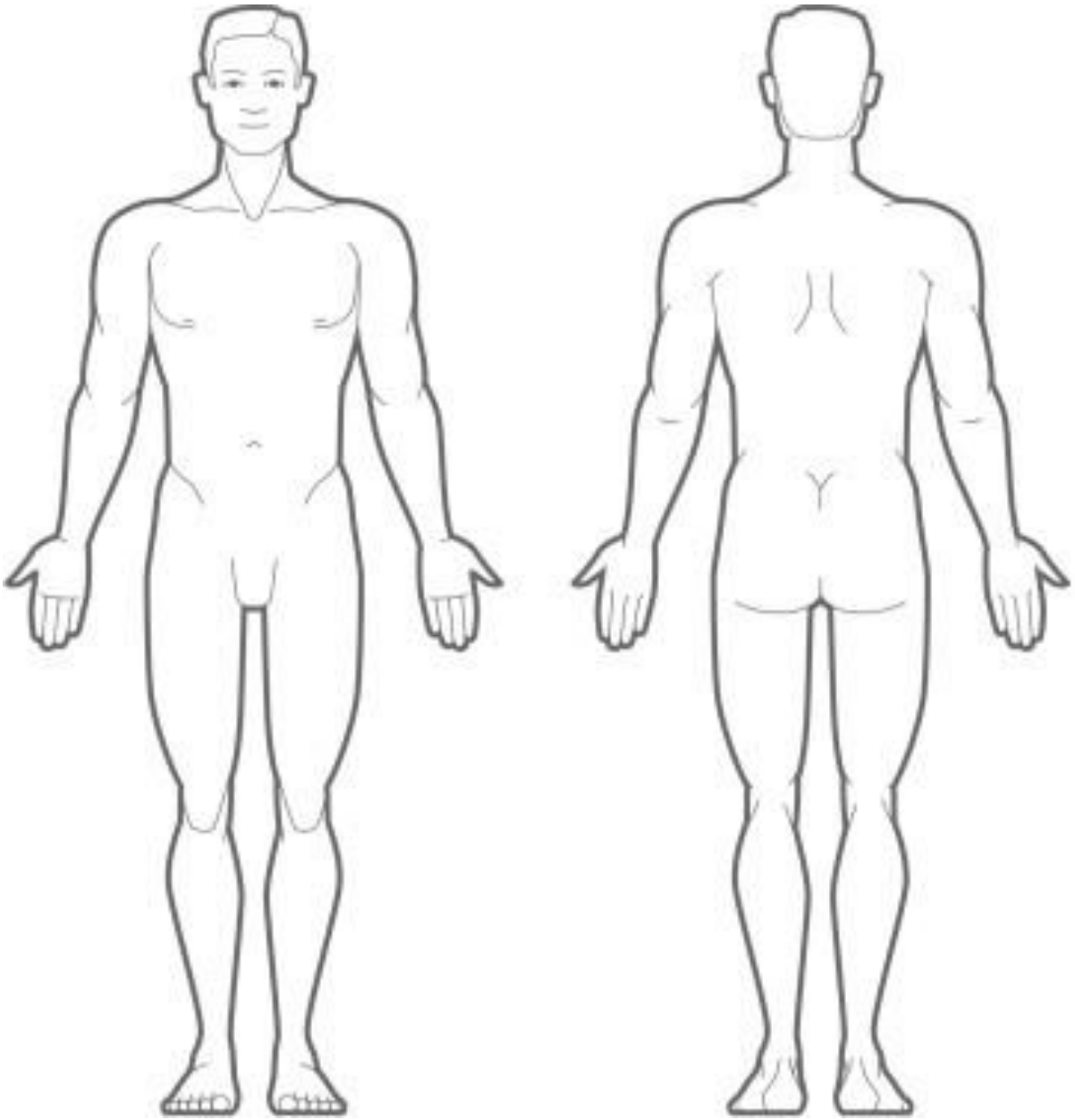
I have completed this health history to the best of my knowledge:

Patient Signature: _____ Date: _____

PHYSI SENSE

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



PHYSI SENSE

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

WORK-RELATED INJURY INFORMATION

Date of Injury: (mm/dd/yyyy)	Area of Injury:
How did the injury occur?	
Have you already received any treatment for this accident? ☐ Yes ☐ No If yes, please indicate the facility:	
Did you miss any time from work because of the accident? ☐ Yes ☐ No	Are you currently back to work? ☐ Yes ☐ No

WSIB CLAIM INFORMATION

Name of Insurance Company: **WSIB**	Claim number:
Insurance Company Address: **Simcoe Place, 200 Front St. West, Toronto, ON, M5V 3J1**	
WSIB Phone: **(800) 387-0750**	WSIB Fax: **(888) 313-7373**
Name of Adjudicator:	Phone number: ( )
Name of Nurse:	Phone number: ( )

LEGAL REPRESENTATION INFORMATION

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

PHYSIOSENSE

IRREVOCABLE DIRECTION AND AUTHORIZATION (WSIB)

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

I hereby irrevocably direct WSIB 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 WSIB 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 WSIB should refuse to make payments for my treatments, I agree that PhysioSense shall have the right, in my name and on my behalf, to submit to my Extended Health Benefits/Private Insurance plan for payment. I agree to fully cooperate with PhysioSense to provide any required documents.

In the event I should refuse to cooperate as noted, I shall pay to PhysioSense the costs of such treatment.

Patient Name: _____

Patient Signature: _____

Date: _____