The Physio Studio

Physiotherapy Patient Intake Form

All information is retained as part of your confidential patient record.

NAME ______________________________

STREET ADDRESS ______________________________

CITY ______________ PROVINCE ______________ POSTAL CODE ______________

HOME# ______________ WORK# ______________ CELL# ______________

DATE OF BIRTH: M_____ D_____ Y________ EMAIL ADDRESS ______________

OCCUPATION ______________ EMPLOYER ______________

EMERGENCY CONTACT: ______________ PHONE # ______________

FAMILY DR. ______________ PHONE # ______________

REFERRING DR. ______________ PHONE # ______________

ARE YOU HERE AS A RESULT OF A MOTOR VEHICLE ACCIDENT (MVA)? YES NO

(IF YES) NAME OF YOUR AUTO INSURANCE COMPANY: ______________

INSURANCE ADJUSTER: ______________ PHONE # ______________

CLAIM # ______________ POLICY # ______________ FAX # ______________

DATE OF ACCIDENT (MONTH/DAY/YEAR) ______________

(MVA ONLY) DO YOU HAVE PRIVATE MEDICAL COVERAGE? YES NO

NAME OF MEDICAL INSURANCE COMPANY: ______________

POLICY/PLAN NUMBER: ______________ ID NUMBER : ______________

PERCENTAGE COVERED: ______________ % TO MAXIMUM OF: $ ______________

IS YOUR INJURY COVERED BY WSIB (WORKPLACE SAFETY AND INSURANCE BOARD)? YES NO

(IF YES) WSIB CONTACT NAME AND PHONE NUMBER ______________

CLAIM#______________ DATE OF ACCIDENT ______________

*If this is a MVA, the OCF 1 must be completed and returned to your Auto Insurance Company. If not, you will be responsible for all fees.

*WORKER'S COMPENSATION CLIENTS: If, for any reason, WSIB declines to cover your Physiotherapy Claim, you will be responsible to pay the outstanding balance on your account

*PLEASE NOTE that OHIP does not cover Private Physiotherapy or Massage Therapy in Ontario.
Therefore, you or your medical insurance company are directly responsible for payment of any services provided to you by The Physio Studio. Payment must be made after each session. Initial assessments must be paid for at the time of your first visit.

NAME ______________________________ DOB______________

The Physio Studio

Are you presently receiving or have you ever received any of the following treatments for your current condition?

Chiropractic	Massage	Occupational Therapy	Naturopathic
Reflexology	Acupuncture	Physiotherapy	Podiatry/Chiropody

Please check any of the following conditions that you have:

Arthritis	Cough	Recent Falls/Blackouts
Hernia	Metal Implants	Asthma
Diabetes	Pacemaker	Unexplained Weight Loss
Depression	Vision Difficulties	Bronchitis
Thyroid Condition	History of Cancer	Groin Numbness/Tingling
Osteoporosis	Swallowing Difficulties	Respiratory Condition
Dizziness/Fainting	Allergies to tape/latex	Bowel/ Bladder Difficulties
Smoking History	Slurred Speech	Hearing Impairment
Low/High Blood Pressure	Any Allergies	Headaches
Raynauds	Memory Problems	Pregnancy
Heart Condition	Epilepsy/Seizures	Blood Diseases
Sleeping Problems	Balance Problems	Other: ____________________
Chest Pain	Shortness of Breath	

PREVIOUS INJURIES/SURGERY: ____

____

Is there anything else we should know about your health? ______________________________

____

What do you expect/hope to achieve from therapy? ___________________________________

Please list any medications you are currently taking: ________________________________

____

Please circle any test you have underwent in the last 3 months for your current complaint/condition.

X-rays **CT Scan** **EMG/nerve conduction** **MRI** **Bone Density Study** **Ultrasound**

Other (specify) ____

The Physio Studio believes that it is important to establish and maintain clear lines of communication with all parties involved in the successful rehabilitation of your injury. As a result, information relating to your treatment progression and treatment plans may be shared with your physician, case manager, employer and/or third party payer.

I, ______________________________________**(please print your name)**, do consent to being treated/ assessed by The Physio Studio. I hereby authorize the release of my assessment or progress notes, or any other medical information to my: **(Please fill in appropriate names)**

NAME ______________________________ DOB______________

The Physio Studio

____
(Family Physician/Specialist)

____
(Lawyer)

____
(Insurance Company)

____
(Physiotherapist/Other Medical)

____
(Workers Compensation Board)

____
(Employer Representative/Other)

Or, I accept responsibility for ensuring that my report is taken to the appropriate appointment

PAYMENT POLICY

•PAYMENT IS DUE ON THE DATE SERVICE IS RENDERED, BEFORE SEEING YOUR TREATING PRACTITIONER. We accept cash, debit, cheque and all major credit cards as payment for services rendered.

•We reserve the right to turn any patient over to collections if the account is in default of the payment obligation or compliance with this policy.

•I agree to forever hold harmless The Physio Studio, their service providers and staff, for refusal to render further services in the event I do not honor this financial agreement.

______________________________ ______________
Signature of client/guardian Date

______________________________ ______________
Signature of witness Date

Cancellation/No Show policy

Our office requires 24 hours notice of any appointment cancellation. If you do not show for your appointment you may be subject to a $20.00 “No Show” fee.

Signature ______________________________ Date ______________________

NAME ______________________________ DOB______________

The Physio Studio

Informed Consent to Physiotherapy

CONSENT TO ASSESSMENT/TREATMENT:

I acknowledge that I have discussed, or have had the opportunity to discuss, with my Physiotherapist the nature and purpose of my treatment in general and my treatment in particular as well as contents of this consent. I hereby authorize and grant permission for The Physio Studio Physiotherapy to carry out any assessment and examination procedures and treatments as may be necessary to assess and treat my condition or injury.

The Physiotherapist agrees to provide me with understandable information on the following:

- My diagnosis as known
- The treatment being suggested
- The important effects, risks and side effects of the treatment
- Possible alternatives to having this treatment; reasonable additional procedures which may be neccessary and the potential risks of foregoing the suggested care

Initial_________

CONSENT TO TREATMENT WITH SUPPORT PERSONAL:

I agree to participate in treatment with a Physiotherapy Assistant when appropriate in order to enhance my recovery, which includes but is not limited to the following providers: Certified Athletic Therapist, Kinesiologist, Certified Strength and Conditioning Coach, and Certified Personal Trainer. I understand that the treatment I undergo may be administered in part or in full by my Physiotherapist and/or by the Physiotherapy Assistant under the supervision of my Physiotherapist. I acknowledge that my Physiotherapist has provided me with information that is pertinent to my assessment and treatment, including the possible risks and side effects of the proposed treatment.

Initial_________

CONSENT FOR PERSONAL INFORMATION:

Maintaining the protection of your personal or health information is importation to The Physio Studio. Our company is committed to collecting, using and disclosing personal or health information responsibly and ONLY to the extent necessary for the services provided.

Your consent must be freely given and you must understand the purposes for which The Physio Studio will collect, use or disclose your personal or health information before giving your consent. Also, you must understand that you are able to withdraw your consent at any time.

Purposes fo the collection, use and disclosure of your personal health information by The Physio Studio:

- To provide assessment, treatment or other services related to your injury condition, and/or your claim for compensation of benefits.
- To obtain payment for assessment, treatment or other services we provided and determine any entitlement to insurance coverage or other benefits.
- To identify treatment outcomes and share this information with payers (ie. your insurance company),
- and/or referral sources (ie. your family doctor)

Initial_________

NAME ______________________________ DOB______________

The Physio Studio

Health Information Custodian:

I understand that the Health Information Custodian assigned to my health record is Lori Karikari, Registered Physiotherapist. I understand that if I have any complaint, or if I require information pertaining to my health record, I can discuss these matters with Lori Karikari. Lori Karikari's contact information is: lori@physiostudio.ca or alternatively, she can be reached by phone at 905.665.1999. I also understand that elements of these duties may be assigned to an agent (ie. alternative The Physio Studio staff member).

Initial__________

Withdrawing my consent :

I understand that I may withdraw my consent, in whole or in part, at any time upon providing reasonable written notice to my treating health care provider. I understand that potential consequences of doing so may limit the ability of The Physio Studio to provide my assessment, treatment or other services. If I withdraw my consent, I understand that this is not retroactive, and does not apply to personal or health information already collected, used or disclosed by The Physio Studio.

Initial__________

I have read the above information and indicate my consent by my signature below. My consent is valid unless and until I withdraw it in the manner set out in this consent form.

______________________________ ______________
Signature of client/guardian Date

______________________________ ______________
Signature of witness Date