Holly Physiotherapy & Rehabilitation

Better with care

NAME: _____ DATE: _____

ADDRESS: _____ PHONE: (h) _____

CITY/PROV:_____ Postal Code_____ (w) _____ (c) _____

OCCUPATION: _____ DATE OF BIRTH: _____

FAMILY DR.: _____ EMAIL: _____

Which referral source brought you to Holly Physiotherapy & Rehabilitation? _____

PLEASE CHECK ANY OF THE FOLLOWING WHICH ARE APPLICABLE TO YOU:

General health status: □Poor □Fair □Good □Excellent

Allergies: _____

Skin Conditions: _____

Respiratory Conditions:
- □ Asthma
- □ Chronic cough/bronchitis
- □ Shortness of Breath
- □ Emphysema

Cardiovascular Conditions:
- □ High Blood Pressure
- □ Low Blood Pressure
- □ Congestive Heart Failure
- □ Heart Attack
- □ Stroke
- □ Pacemaker or similar device

Infections:
- □ Hepatitis
- □ TB
- □ HIV

Arthritis: _____

Other Conditions:
- □ Diabetes
- □ High Cholesterol
- □ Epilepsy
- □ Cancer
- □ Headaches
- □ Dizziness
- □ Fainting
- □ Vision/hearing loss
- □ Pins, plates, prosthetics

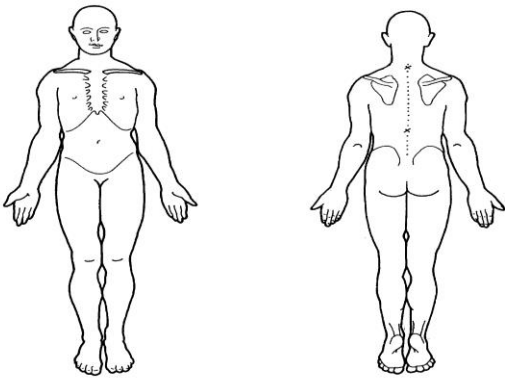
Women: Are you pregnant? ____

Other Medical Conditions: _____

Past Surgery: _____ Date: _____

Current Medication: _____

Indicate any painful area by circling the affected area:



Is this a result of an injury? YES / NO MVA/WSIB

If yes, date of injury? _____

Details of the injury events: _____

_____

Current treatments received: _____

_____

Please note 24 hours notice is required for cancellation of an appointment. Any unpaid expenses incurred by your insurance carrier is payable by the undersigned.

Signature: _____

HOLLY PHYSIOTHERAPY & REHABILITATION

BETTER WITH CARE

Your Responsibility to Us

(Cancellation and Payment Policy)

Cancellation Policy

I understand when I book an appointment time with my therapist, this time is reserved for me and as such, I will provide 24 hours notice should I need to cancel any appointment to allow enough time to fill this appointment with other waiting clients. Failure to do so may result in a cancellation fee charged directly to me directly as it cannot be billed to any insurance company. I understand the therapists do their best to keep to their assigned schedules. I will try to be prompt for my appointment to ensure that everyone receives adequate treatment time.

Payment Policy

I understand payment for each treatment is due when the service has been given.

Direct (Insurance & WSIB) Billing

Some insurers do allow the clinic to bill directly for services. If I wish to take advantage of these services I will ask the administrative staff to see if this service applies for my benefits. I understand if the clinic bills an insurance company or WSIB directly on my behalf, the account still remains my responsibility should payment be denied.

Motor Vehicle Accident Coverage

I understand in order for my insurance company to provide coverage for services, I must complete the application for benefits package which was sent to me when I filed my accident claim. My therapist will complete a treatment plan outlining my rehabilitation process and submit it to my insurance company directly. I understand the auto insurer is unable to approve any therapy without receiving the fully completed package.

As outlined in the Statutory Accident Benefits Schedule, any extended healthcare plan coverage must be exhausted before the auto insurance company will provide payment for any unpaid portion from this plan. I understand it is my responsibility to ensure that the extended health claims forms are sent to my carrier and that **payment is returned** to the clinic before the auto insurer can be invoiced by the clinic on my behalf.

Should a balance remain unpaid by insurance, extended health benefits or WSIB, that balance is also my responsibility and I will remit payment or discuss payment options as soon as possible. I understand a 1% per month interest charge will apply to outstanding accounts. A NSF charge of $50 will apply to all cheques denied at the bank.

I have read and understood the above mentioned policies and agree to their terms and conditions.

Signed: _____ Date: _____

HOLLY PHYSIOTHERAPY & REHABILITATION

BETTER WITH CARE

Consent Form

We require your informed consent. This entails your understanding of the services we provide, the costs involved and how your personal information is protected. If you have any questions regarding the same, please inquire.

CONSENT TO OBTAIN

I authorize Holly Physiotherapy & Rehabilitation or its representatives to obtain information and documentation relevant to my assessment and treatment. Further, a photocopy of this signed consent is sufficient authority to release this information.

CONSENT TO RELEASE

I authorize Holly Physiotherapy & Rehabilitation or its representatives to release information and documentation relevant to my assessment and treatment. Further, a photocopy of this signed consent is sufficient authority to release this information.

CONSENT FOR PERSONAL INFORMATION

I understand that to provide me with physiotherapy, massage or acupuncture treatment, Holly Physiotherapy & Rehabilitation will collect relevant information about me (ie., address, telephone number, date of birth, doctor's name, health history, etc.).

I agree to Holly Physiotherapy & Rehabilitation collecting, using and disclosing personal information about me as set out above and in Holly Physiotherapy & Rehabilitation Privacy Policy.

I also declare _____(name of family member) may request information as it relates to my appointment bookings/cancellations and whether I attended my visits at the clinic. (Ie a parent requesting information about an age of consent teenager patient, spouse inquiry, etc.)

SIGNATURE:_____ DATE:_____

PRINTED NAME: _____DATE OF BIRTH:_____

ADDRESS:_____ CITY/PROV:_____ Postal Code: _____

TELEPHONE: _____HEALTH CARD NUMBER:_____

WITNESS:_____