talbot trail PHYSIOTHERAPY

PATIENT INFORMATION

PLEASE NOTE THAT OUR SERVICES ARE NOT COVERED BY OHIP

Name: _____ Date of Birth (YYYY/MM/DD): _____

Address: _____ City: _____ Postal Code: _____

Home Tel: _____ Work Tel: _____ Other Tel: _____

Place of Employment: _____

Referring Physician: Dr. _____ Family Physician: Dr. _____

(First Name & Last Name) (First Name & Last Name)

Address: _____ Address: _____

Phone #: _____ Phone #: _____

***If patient is a minor, parent/guardian please complete the following*:**

Guardian Name: _____ □ Guardian Address/Phone number same as patient

Address: _____ City: _____ Postal Code: _____

Home Tel: _____ Work Tel: _____ Other Tel: _____

MEDICAL HISTORY (Please Circle)

Do you have?

YES NO Metal Implants? If YES, Where? _____

YES NO Pacemaker? ***IMPORTANT: Electrical Modalities may interfere with Pacemakers***

YES NO Joint Replacement?

Have you ever been or are you currently being treated for any of the following?

YES NO High Blood Pressure? _____

YES NO Fibromyalgia? _____

YES NO Diabetes? _____

YES NO Cancer, Radiation Therapy? If YES, when was it diagnosed? _____

Where is/was the cancer located? _____

YES NO Heart/Kidney Problems? _____

YES NO Hyperthyroidism / Hypothyroidism? _____

YES NO Stroke? _____

YES NO Epilepsy? _____

YES NO Hemophilia? _____

YES NO Fractures? _____

YES NO Lung/Breathing? _____

YES NO Other? _____

YES NO Are you allergic to Latex or products such as Elastoplasts, Band-aids or Tape?

_____

YES NO Do you have a tendency of fainting or blacking out? _____

Reason for Treatment Today? _____

Please list ALL medications you are currently taking _____

_____

FEMALE PATIENTS ONLY:

Are you Pregnant? YES___ NO___ If yes, what is your Due Date (M/D/Y)? _____

If this information should change please notify the Therapist

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PATIENTS WITHOUT PRIVATE INSURANCE WILL BE INVOICED DIRECTLY.

PRIVATE INSURANCE

If you have any of the following Insurance Carriers, please check and complete all that apply.

□ **Sun Life** (Pol # _____ ID#_____) □ **Great West Life** (Pol # _____ ID#_____)
□ **Standard Life** (Pol#_____ ID#_____) □ **Industrial Alliance** (Pol # _____ ID#_____)
□ **Johnson Inc** (Pol # _____ ID#_____) □ **Chamber of Commerce** (Pol # _____ ID#_____)
□ **Blue Cross** (Pol # _____ ID#_____) □ **Greenshield/SSQ** (Pol # _____)
□ **Veterans Affairs** (K #_____)

Name of Policy Holder: _____ **Policy Holder's Date of Birth:** _____

*For all other insurance companies, we request that you pay your account **daily** and submit receipts to your insurance company directly for reimbursement.*

Note: During the course of treatment at Talbot Trail Physiotherapy, your healthcare provider may suggest a number of therapeutic options to improve your physical function in the shortest amount of time. If you have benefits, please check those therapies that are covered in your plan:

☐ **Physiotherapy** ☐ **Chiropractor** ☐ **Acupuncture** ☐ **Hydrotherapy** ☐ **Massage** ☐ **Orthotics** ☐**Shockwave Therapy**

I AM AWARE OF WHAT MY BENEFITS COVER. I UNDERSTAND AND AGREE THAT MY ACCOUNT IS MY RESPONSIBILITY, AND I WILL MAKE PROMPT PAYMENT SHOULD MY INSURANCE NOT COVER. (We accept DEBIT, MASTERCARD, VISA and CASH)

_____ _____
PATIENT'S SIGNATURE DATE

If your injury is a **WORKERS COMPENSATION (WSIB) CLAIM,** please complete the following:

Claim Number _____ Health Card Number _____

SIN # _____ Date of Accident (D/M/Y) _____

Employer's Address & Phone #: _____

Adjuster's Name & Phone #: _____

Have you had previous Physiotherapy for this injury before now? _____

IF YOUR CLAIM IS REJECTED BY WSIB, IT IS YOUR RESPONSIBILITY TO PAY FOR YOUR VISITS.

_____ _____
PATIENT'S SIGNATURE DATE

If your Injury is from a **MOTOR VEHICLE ACCIDENT (MVA),** please provide the following:

Policy # _____ Claim #_____

Date of Accident: _____

Name and Address of Insurance Company: _____

_____

_____

Name and Phone # of your Ins. Representative: _____

_____

_____ _____
PATIENT'S SIGNATURE DATE

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PATIENT CONSENT FORM

Thank you for selecting Talbot Trail Physiotherapy (TTP) to assist you in providing high quality, one-on-one services to help you achieve your maximum level of physical function for life-long mobility.

During your initial visit, the therapist will explain your diagnosis and discuss treatment recommendations. ***Please note, that the success of your treatment is dependent upon your participation in the treatment plan agreed upon with your therapist.*** If at any time you have questions regarding treatment and services provided, please do not hesitate to talk to your therapist.

CONSENT FOR TREATMENT

I hereby consent to the rendering of evaluations, treatments and/or services as deemed appropriate by **Talbot Trail Physiotherapy.**

CONSENT FOR THE COST OF OUR SERVICES

I am aware that there are charges for services rendered, and depending on the services, the charges will vary. Initial assessments are scheduled for 45 min. to allow the therapist to complete the full assessment. (**Note**: MVA/WSIB rates differ from Private or Insurer rates).

Initial Assessment	= **$60**	Concussion Initial Assessment	= **$90**	Women's Health Initial Assessment	= **$120**
Follow-up visits	= **$45**	1st Concussion Follow-up visit	= **$75**	Women's Health Follow-up visits	= **$90**
Acupuncture	= **$45**	Concussion follow-up visits	= **$45**	Shockwave Therapy	= **$125**

Missed / Cancelled (without 24 hrs notice) Appointments = **$25**

ELECTRONIC TRANSMISSION AUTHORIZATION

I hereby assign benefits payable (for the eligible claims) to the Provider responsible for submitting my claims and/or my family's claims electronically to the group benefits plan, and I authorize the insurer/plan administrator to issue payment directly to **TTP**. I also authorize my spouse and/or dependents to assign benefit payments under the plan to the healthcare provider. If any payment is sent directly to me, I agree to forward it to **TTP. In the event my claim(s) and/or my family's claim(s) are declined by the insurer/plan administrator, I understand that I remain responsible for payment to the Provider for any services rendered and/ or supplies provided.**

In the event that the Workplace Safety & Insurance Board (WSIB) does not allow payment for services rendered, I agree to pay **TTP** all incurred fees until I have been reimbursed from **WSIB.**

CONSENT FOR EMAIL COMMUNICATION

I hereby give consent for my **EMAIL ADDRESS:** _____ to be used for the following:

□ Personal: exercise program, upcoming appointments, and friendly reminders

□ Newsletter: ways to improve your treatment experience

TTP will never share your email address with a third-party. □ Decline

CONSENT FOR PERSONAL INFORMATION

I understand that in order to provide me with therapeutic goods and services, **TTP** will collect personal information about myself and/or my family (e.g., address, date of birth, home telephone number). I confirm that I am authorized by my spouse and/or dependents, if any, to disclose personal information about them to the plan administrator and their service provider(s) and I confirm that my spouse and/or dependents also authorize the insurer and/or plan administrator and their service provider(s) to disclose information about their claims to me, for the purposes of assessing and paying a benefit, if any, and managing the group benefits plan. I have reviewed **TTP'S Privacy Policy** about the collection, use and disclosure of personal information, steps taken to protect the information, and my right to review my personal information. I understand how the Privacy Policy applies to me and have been given the opportunity to ask any questions about the Privacy Policies, and they have been answered to my satisfaction.

I understand that, as explained in the Policies and Procedures for Personal Information, there are some rare exceptions to these commitments. A copy of the privacy policy is available on request.

I agree to **TTP** collecting, using and disclosing personal information about me as set out above, and in the **TTP** Privacy Policy.

I authorize Talbot Trail Physiotherapy the use of any photographs, videos, testimonials and recordings of me for promotional and marketing purposes. □ **Yes** □ **No**

I hereby authorize and direct to make copies of, and release to **TTP,** all information of a medical nature, including x-ray reports, nurses' notes, medical notes, operative notes and generally anything relating medically to the undersigned.

SIGNATURE: _____ DATE: _____

PRINT NAME: _____

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HOW DID YOU HEAR ABOUT OUR CLINIC?

*(Please check **ALL** that apply)*

Insert check mark

1. Closing File/Friendly letter from Talbot Trail Physiotherapy ..... ☐

2. Internal referral:
   - Dr. Cervinka ..... ☐
   - Dr. Van Houwelingen ..... ☐
   - Dr. Leaf ..... ☐
   - Other Talbot Trail Physiotherapy Clinic ..... ☐
   - Talbot Trail Staff Member *(Name)* _____ ☐
   - Family Member or Friend *(Name)* _____ ☐
   - Previous Talbot Trail Physiotherapy patient ..... ☐

3. External Referral:
   - Family Dr. *(Name)* _____ ☐
   - Orthopaedic Surgeon *(Name)* _____ ☐
   - Nurse Practitioner *(Name)* _____ ☐
   - Emergency Dept. *(Hospital)* _____ ☐
   - Concussion Baseline Testing _____ ☐
   - Bumps & Bruises Clinic *(Specify School)* _____ ☐
   - Walk-In Clinic *(Location)* _____ ☐
   - WSIB/Insurance Co. *(Company Name)* _____ ☐

4. Saw Talbot Trail's Advertisement(s) in:
   - Google ..... ☐
   - Facebook ..... ☐
   - Website (www.TalbotTrailPhysiotherapy.ca) ..... ☐
   - Yellow Sign ..... ☐
   - Phone Book ..... ☐
   - Talbot Trail Brochure ..... ☐
   - Talbot Trail Physiotherapy Poster/Signage *(which one)* _____ ☐
   - Radio advertisement ..... ☐
   - Talbot Trailblazer Newsletter ..... ☐