

PATIENT INTAKE INFORMATION

Patient Information			
Last Name on CareCard:		First Name on CareCard:	Middle Name on CareCard:
Phone (Main #):		Phone (Alternate #):	Email Address:
Address:		City:	Postal Code:
Birthdate (mm/dd/yyyy):		MSP CareCard #:	Emergency contact and phone #:
Date of Injury (mm/dd/yyyy):		Claim Type:	
		<input type="checkbox"/> WCB <input type="checkbox"/> ICBC <input type="checkbox"/> Personal <input type="checkbox"/> MSP Exempt <input type="checkbox"/> RCMP <input type="checkbox"/> DVA	
Medical Team			
Family Physician:		Referring Physician:	Specialist(s):
How did you find our clinic?			
<input type="checkbox"/> Yellow Pages <input type="checkbox"/> Signs <input type="checkbox"/> Existing patient <input type="checkbox"/> Friend / Family <input type="checkbox"/> Internet <input type="checkbox"/> Family Physician <input type="checkbox"/> Referring Physician <input type="checkbox"/> The Link <input type="checkbox"/> Fraser Health <input type="checkbox"/> Other: _____			
Fill out only if WCB or ICBC			
Claim Number:	Adjuster Name:	Adjuster Phone #:	Adjuster Fax #:
Fill out only if RCMP or DVA			
RCMP #: R _____		Veteran Affairs #: K _____	
Extended health insurance. ** Bring your policy number and our office staff will check your coverage.			
Physiotherapy coverage:	Massage Therapy coverage:	Orthotics coverage:	
Yearly max: _____ Details:	Yearly max: _____ <input type="checkbox"/> Doctors note required? Details:	Yearly max: _____ <input type="checkbox"/> Physio note required? <input type="checkbox"/> Doctors note required? Details:	

OFFICE SECTION ONLY			
Assessment date	Description (le ICBC – Shoulder)	Primary provider	Billing office
			Glover Physiotherapy
WCB/ICBC diagnosis cd	WCB body part#	WCB injury #	End date
The following must be complete for all new patients:			
<input type="checkbox"/> Patient has adequate coverage for physiotherapy <input type="checkbox"/> All fields on all new patient forms are complete <input type="checkbox"/> All fields on this form are entered into the computer program			

Patient Consent Form

1) Informed consent and consent to treatment.

I have been informed about my conditions at Glover Physiotherapy and give voluntarily consent to participate in the assessments and treatment outlined by the service provider. I understand that this will involve my active participation and I will comply with the provider's recommendations in order to enhance my recovery. I acknowledge that my provider has provided me with information that is pertinent to my treatment, including the possible risks and side effects. These risks include but are not limited to redness, bruising, burns, re-injury, muscle sprains/strains, fractures, damage to dental work, headache. I understand that the assessment and treatment services I undergo may be administered by the treating provider and/or by trained support staff working under the supervision of the treating provider. I understand that anytime during the course of treatment, I am responsible for my own actions. I understand that I am not to engage in activity in the clinic if I have not been given proper instruction. I understand that at certain times, students may be at the clinic for educational purposes. I agree to allow my information to be shared and discussed within the clinical setting. I agree to allow access to students to interact with me when required.

2) Consent to collect and disclose personal information.

Personal information that Glover Physiotherapy collects, retains, uses, and discloses may include, without limitation, your name, age, contact information, health benefit information, occupation information, personal health information, medical history, and other information deemed necessary to fulfill the following purposes:

- ✓ To provide assessment and treatment services.
- ✓ To comply with the requirements of professional regulatory bodies, including file audits.
- ✓ To invoice you directly for services provided, and to process payment for those services.
- ✓ To provide information to Third Party Payers, Physicians and Legal Counsel already involved in your care
- ✓ To determine best clinical practices and ensure quality of service by the staff of Glover Physiotherapy.

I understand that Glover Physiotherapy may use, share, disclose and retain my personal information, in order to fulfill the purposes noted above, or where otherwise permitted by law. I hereby give Glover Physiotherapy permission and consent to maintain personal information on file. When requested, I hereby give consent for information to be released as required unless specified in writing.

3) Consent to be contacted.

I give consent that I may be contacted at any of the phone numbers and/or mailing addresses provided to Glover Physiotherapy. I give consent to Glover Physiotherapy to leave messages at my contact number. In the case of a change in address or telephone number, I give Glover Physiotherapy consent to release information as needed so that I may be contacted.

4) Consent for payment.

I agree that in the event that I cannot attend my scheduled physiotherapy appointment(s), that I will make every effort to notify and inform Glover Physiotherapy at least 24 hours prior to my scheduled appointment. If I am unable to give appropriate notice of cancellation, I agree to pay a \$ 25.00 missed or late physiotherapy cancellation fee. Treatment may be suspended until the account has been paid in full.

Current Medications (amount and frequency)	Allergies and Reactions (include medications)	
Medical History (List Medical Conditions e.g. Heart problems, diabetes, seizure disorder, asthma, high Blood Pressure)		
Surgery		
Physical Activities Readiness Questionnaire	Yes	No
Has your MD ever said that you have a heart condition <u>and</u> is your physical activity being limited?		
Do you feel pain in your chest when you do physical activity? Have you had pain in the last month?		
Do you lose your balance because of dizziness or do you ever lose consciousness?		
Do you have a bone / joint problem that could be made worse by a change in your physical activity?		
Is your doctor currently prescribing drugs for your blood pressure or heart condition?		
Do you know of <u>any other reason</u> why you should not do Physical activity?		

Glover Physiotherapy requires the patient to agree to the above consents (Consent for Treatment, Consent to Collect and Disclose personal information, Consent for the cost of our services, Consent for payment) prior to the initial treatment consultation. I hereby give Glover Physiotherapy my permission and consent for all of the above.

Patient signature

Date

Witness signature

Date

OFFICE POLICY

Appointments:

- ✓ Please be on time, sign in for each of your appointments and bring your appointment card
- ✓ Book your appointments at the beginning of each week for the next week
- ✓ Cancel your appointment if you are unable to attend, if you miss several appointments without reason, we may have to notify your physician or insurance company and you may be discharged
- ✓ Patients will be charged \$25.00 for all missed appointments.

Clothing and attire:

- ✓ Wear appropriate footwear. Runners only. No work boots, open toe shoes, slip on's or heels.
- ✓ Wear appropriate workout attire (t-shirt, sweatshirt , sweatpants , shorts).
- ✓ No perfumes, strong body odors, or excessive scents
- ✓ It is appreciated if all patient's wear clean clothes & have proper hygiene.

Safety:

- ✓ Children must be under adult supervision and are not to play with any equipment
- ✓ Please notify your treating therapist of any change in your condition or anything you are unsure about
- ✓ Please call for assistance immediately if you are in any discomfort during your treatment
- ✓ If you have inhalers or nitro spray, please have it with you at all times while in the clinic

Food and Drinks:

- ✓ No food or drinks are allowed beyond the waiting room area.

Lost or Stolen Items:

- ✓ We are not responsible for any items lost or stolen while attending our facility.
- ✓ Please do not bring or wear expensive or irreplaceable items with you to your treatment sessions, they may have to be removed in order for you to receive treatment.

Reports/ Work Notes:

- ✓ A fee will be charged for reports and / or work notes
- ✓ Please see our receptionist for further details.

Worker's Compensation Claims (WorksafeBC) / Work Injuries:

- ✓ If you are attending treatment as a result of a work injury, you must report your injury to the appropriate agencies.
- ✓ You are also responsible for providing our office with your claim number as soon as it is issued.
- ✓ Our office staff would be happy to assist you with this in any way possible.
- ✓ Please be aware that if your claim through WorksafeBC is denied, you are responsible for any and all charges accrued for your treatment at our facility.

Private Insurance Coverage:

- ✓ Most extended health benefits cover physiotherapy and massage therapy.
- ✓ Please contact your policy administrator for details for reimbursement
- ✓ You are responsible for paying at the time of visit

Motor Vehicle Accident Injuries (ICBC):

- ✓ If you are attending treatment as a result of a motor vehicle accident, you must provide our office with all the relevant information (claim number, adjustor name, etc.) for us to process your claim.
- ✓ Our office staff would be happy to assist you with this in any way possible.
- ✓ Please be aware that if your claim through ICBC is denied, you are responsible for any and all charges accrued for your treatment at our facility.

Patient Signature

Date