

Personal

Please read & fill in all information in details

All the information in this section has not changed since my last visit. Please proceed to the Referral Section below.

First Name: _____ Last Name: _____ Date of Birth: _____

(Mm/dd/yyyy)

Current Address: _____

City: _____ Province: _____ Postal Code: _____

Email Address: _____ Cell Phone: _____

Home Phone: _____ Work Phone (optional): _____

Health Card No _____ Gender: Male / Female

Emergency Contact Person

Relationship

Phone

Physician Details:

Family Physician

Full Name: _____ Clinic Name: _____

Clinic Number _____

Incident Physician

Full Name: _____ Clinic Name: _____

Clinic Number _____

Referral:

How did you hear about us: Brentwood Community, Google, Physician _____, Newspaper/Magazine

Friends/Relatives(full name) _____, Other _____

For Prenatal Clients Only - Please Fill in What Applies To You:

- I may be pregnant I am pregnant
 This is my 1st, 2nd or _____ Pregnancy
 I am _____ (number) week(s) in my _____ (1st, 2nd, 3rd) trimester

Anything else you would like your therapist to know? _____

Please read the Consent for Prenatal Physiotherapy

For MVA only Have you completed Accidents Benefits Package (AB1 & AB2)? Yes No

For WCB only Have you completed WCB Intake form Yes No

For Private only Have you completed Direct Electronic Submission Form Yes No



Consent

Consent for Assessment and Treatment:

Assessing physiotherapist will collect all the necessary information pertaining to your injuries for assessment purpose. Explain the treatment techniques that may include Manual Therapy to Joints and Muscles, use of therapeutic electrical modalities, Acupuncture (use of needles) if needed, Exercise therapy. Your Physiotherapist will also explain the benefits and side effects if any during the treatment period. It is your responsibility to inform the treating therapist if you **DO NOT** understand assessment and treatment plan. At any time if you choose not to continue to participate in the treatment plan you must inform the treating therapist immediately.

I **UNDERSTAND**, & choose to continue with assessment & treatment

Patient/Parent/Guardian Signature: _____

Date: _____

If you are under the age of 18, Parent/Guardian must sign

Representative Witness Signature: _____

Date: _____

Consent for Prenatal Physiotherapy

_____ (sign), I authorize *Crowchild Physiotherapy* to administer physiotherapy to me during my pregnancy. I understand that *Crowchild Physiotherapy* strongly encourages me to communicate with my physician about the potential benefits and risks.

Medical Records Consent

Release of Medical Record:

I authorize *Crowchild Physiotherapy* to **Release or Request** any information from **Physicians, Diagnostic Centers, Insurance Companies, Employers, and Law Firms** with respect to my care.

Patient/Parent/Guardian Signature: _____

Date: _____

If you are under the age of 18, Parent/Guardian must sign

Billing & Payment

Payment for Service Acknowledgement

I authorize *Crowchild Physiotherapy* to submit claims on my behalf to my insurance company and I am responsible to pay any co-payment or any outstanding balance for my physiotherapy & massage services at each time of the appointment upon arrival. In the event my insurance company denies the payment for any reason, **I would be solely responsible to pay for my physiotherapy & Massage services. OR** If the client does not carry any insurance coverage, then Client is fully responsible to pay the complete fee amount for his/her Physiotherapy/ Massage services at each time of the appointment upon arrival.

Patient/Parent/Guardian Signature: _____

Date: _____

If you are under the age of 18, Parent/Guardian must sign

Cancellation Policy

Please provide **24 HOURS** cancellation notice for all **Physiotherapy / Massage** appointments. We reserve the right to charge the cancellation fee for all cancelled or missed appointments without **24 Hours'** notice.

Please note that your Insurance is not responsible to cover the cost of the cancellation fees.

PHYSIOTHERAPY CANCELLATION FEE: Per Session \$30

I have read, understood and agreed to the cancellation policy as stated above.

Last Page

Patient/Parent/Guardian Signature: _____



Medical Authorization Permission

Attention: Medical Records Dept.
Clinic/hospital/physician/law firm/employer

Date: (mm/dd/year) _____

Patient's name:

AHS #:

Date of birth:

Date of Injury Occurred:

I, _____, hereby authorize Crowchild Physiotherapy to Release and Request copies of any or all information from Physicians, Diagnostic Centers, Insurance Companies, Employers, and Law Firms with respect to my care.

Requesting /Releasing: Related to injury due to: MVA WCB General pain/injury

Diagnostic Report: X-Ray Ultrasound MRI Other: _____

Diagnostic report date: _____ Body Part(s): _____
(If available)

Reports: MVA Forms WCB Treatment Charting Notes

OTHER:

*** This authority shall continue until withdrawn, by me, in writing. ***

Patient signature: _____

Date: _____



DIRECT ELECTRONIC CLAIM SUBMISSION AUTHORIZATION

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

Name of the **Primary** Insurance Company: _____

Primary Policy Holder Name: _____ **Date of Birth**
(MM/DD/YYYY): _____

Policy ID/Claim #: _____ Group/ ID: _____

Do you have any other/secondary Extended Health Benefit? _____

Name of the **Secondary** Insurance Company: _____

Secondary Policy Holder Name: _____ **Date of Birth (MM/DD/YYYY):** _____

Policy ID/Claim #: _____ Group ID: _____

Assignment of Benefits Needed? Yes / No

Coverage Period Start: _____ End: _____

Physiotherapy Coverage:

Max Limit: \$ _____ Percentage covered each visit: _____ Deductibles: _____

Does your Insurance required a Doctor's referral for Physiotherapy e-Claims? Yes/No

- If Yes, Physicians Name _____ Date of Referral _____

Massage Coverage:

Max amount Limit: \$ _____ Percentage covered each visit: _____ Deductibles: _____

Does your Insurance required a Doctor's referral for Physiotherapy e-Claims? Yes/No

- If Yes, Physicians Name _____ Date of Referral _____

Custom Foot Orthotics:

Max amount Limit: \$ _____ Percentage covered each Year: _____ Deductibles: _____

Doctor's referral provided for Custom foot Orthotics? Yes / No

If Yes, Physicians Name _____ Date of Referral _____

Did you apply for Custom foot orthotics earlier to your Insurance? Yes/No

- If Yes, Please provide the date of Service _____

CONSENT

- **I hereby certify that Crowchild Physiotherapy has been authorized to submit claims on my behalf to my Insurance Company and the information contained in the claims is complete and accurate.**
- **I am responsible to pay the co-payment, if applicable, at the time of each appointment.**
- **I understand that I am fully responsible to make full payment, if my insurance company denies my claim.**

Signature: _____

Date: _____