WCB Intake form

<u>*Please fill out this form as detailed as possible for WCB insurance purpose***</u>**

WCB Claim #: ________________________________ **Date of injury (dd/mm/yyyy)** ____________________

Worker's Name: _____________________________Worker's Job Title: ________________________________

How did you get injured? ____

____

Did you have similar problem before: Yes / No ____

Have you seen any Doctor immediately after injury occurred? Yes / No

If Yes, Provide Doctor's (Name) ________________________________ Phone: __________________________

When did you see the Doctor (Date-dd/mm/yyyy) ________________________

Company Name and Address: ____

____

Employer Phone #: ___________________________ Manager's Name: ________________________

Nature of Work/ describe your duties at work: ____

____

Did you Report the incident to employer? ____

Have you lost time from work due to injury? ____

If Yes, have you returned to work? _________________

Date of return to work: (dd/mm/yyyy) _______________

Family Doctor: __________________________________

Patient Signature:_________________________ Date: __________________________

Print Name: _____________________________

Crowchild Physiotherapy Massage, Chiropractic at Brentwood Village Centre

PHYSIOTHERAPY – Patient Intake Form

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

Crowchild Physiotherapy Massage, Chiropractic at Brentwood Village Centre

PHYSIOTHERAPY—Patient Intake Form

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.

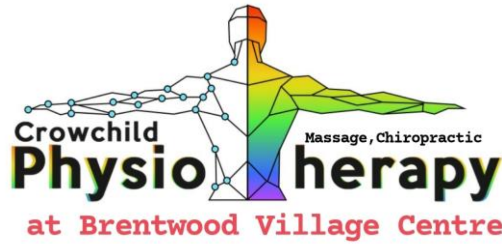
Please note that your Insurance is not responsible to cover the cost of the cancellation fees.

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: _______________________