Nickel Ridge Physiotherapy
Naturopath · Massage Therapy

Physiotherapy Intake Form

Name:		
First Name	Middle Initial	Last Name
Address:		
City:	**Prov:**	**Postal Code:**
Home Phone: ( ) **Cell Phone: ( )** **Work Phone: ( )** **Email:**		
Date of Birth (DD/MM/YYYY)		
Date of Injury:	**Area of Injury:**	

For WSIB Claims	**Date of Injury:**
Claim Number:	
Case Manager:	
Case Manager Phone: ( )	**Case Manager Fax: ( )**

For Motor Vehicle Claims	**Date of Accident:**
Claim Number:	**Policy Holder:**
Auto Insurance Company:	
Address:	**Adjuster's Name:**
Adjuster's Phone: ( )	**Adjuster's Fax: ( )**
Extended Health Coverage:	**Policy Holder:**
Policy/Plan No:	**Certificate/ID No:**

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Physiotherapy Payment/Cancellation Agreement and Consent Form

I understand that payment for services received at Nickel Ridge Physiotherapy is solely my responsibility. If my claim is submitted to a third party payer directly by Nickel Ridge Physiotherapy and for some reason the third party payer (ie. WSIB, motor vehicle or extended health insurance) denies the claim and/or refuses to pay all or any of the full amounts billed, I am responsible for paying the amount outstanding. I understand that the fees per visit for physiotherapy services at Nickel Ridge Physiotherapy are:

Fees:

Assessment $92 Follow-up: $72

Orthotics as quoted – Assessment fee waived upon purchase of any orthotics

Patients are responsible for providing 24 hours notice for appointment cancellations. A $15.00 fee will be charged for any appointments missed or cancelled with less than 24 hours notice.

Physiotherapy assessment and treatment involve the use of manual techniques that involve the application of the therapist's hands on various parts of the patient's body within the comfort of the patient. Treatment techniques may also involve, but are not limited to, the use of spinal mobilizations and/or manipulations, acupuncture or functional dry needling, exercises and electrophysiological modalities (ie. Ultrasound, NMES, TENS). **Some of the techniques utilized by the physiotherapist may have side effects that include, but are not limited to, bruising and soreness.** Treatment options will be discussed with the patient including potential benefits and risks. I understand that I have the right to refuse all or portions of the assessment and treatment at any time.

I hereby acknowledge that I have read, understand and accept the aforementioned conditions and consent to participation in physiotherapy assessment and treatment.

Name (print): _____ Date of Birth: _____

Signature: _____ (if patient is under 18, a guardian must sign)

Date: _____

Witness: _____ Date: _____

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Health Screen

Name:_____ Date of Birth: _____

Have you had or currently have any of the following:

	Yes	No	Explain:
Heart Problems (ie. Arythmia, pacemaker, defibrillator)			
High Blood Pressure			
Low Blood Pressure			
Circulatory Issues (ie. Reynaud's)			
Cancer			
Recent UNEXPLAINED weight loss or gain			
Bowel or Bladder Problems			
Surgeries (previous/recent)			
Diabetes			
Epilepsy/Seizure Disorders			
Osteoporosis (Decreased bone density)			
Osteoarthritis			
Rheumatoid Arthritis			
Asthma or Breathing Problems			
Are you a smoker?			
Are you or could you be pregnant?			
Have you ever tested positive for HIV/AIDS, hepatitis or any other blood bourne disease?			

Any other medical conditions?_____

Medications:

_____

_____