THE PHYSIOTHERAPY PROFESSIONALS

SURNAME _____ FIRST NAME _____ Initial _____

DATE OF BIRTH _____ GENDER male ◯ female ◯
day month year

ADDRESS _____

CITY _____ POSTAL CODE _____

HOME PHONE _____ CELL PHONE _____

WORK PHONE _____ EMAIL _____

EMERGENCY CONTACT name _____ phone number_____

FAMILY DOCTOR _____

ADDRESS _____

PHONE NUMBER _____

How did you hear about our clinic

My doctor ◯ Family or Friend ◯ Sign ◯ Website ◯ Other ◯

INFORMED CONSENT TO PHYSIOTHERAPY/MASSAGE THERAPY ASESSMENT, TREATMENT, AND CARE

I _____ voluntarily give consent to participate in the assessment and rehabilitation program that will be designed for me for my entire course of treatment. Depending on my needs, my program may consist of any of the following: Hands-on manual therapy techniques, therapeutic exercises, electrical and thermal modalities, acupuncture. My treatment program will be designed and monitored by the physiotherapist or massage therapist.

I also acknowledge that I have not been solicited or coerced in any way to seek treatment at this facility and I know that I may seek physiotherapy treatment anywhere I desire.

I realize I may withdraw my consent and discontinue my treatment at any time. By signing below, I intend this consent to cover the entire course of my treatment for my present condition.

_____ _____

Client Signature Date

Client Name _____ D.O.B. _____

MEDICAL AND HEALTH HISTORY

Please check all that apply and provide dates/details.

◯ Osteoarthritis _____ ◯ Osteoporosis _____

◯ Rheumatoid Arthritis _____ ◯ Thyroid Disease _____

◯ HIV/AIDS _____ ◯ Hepatitis _____

◯ Diabetes _____ ◯ Asthma _____

◯ Cancer _____ ◯ Stroke _____

◯ High Blood Pressure _____ ◯ Heart Disease / Attack / Angina _____

◯ Smoking _____ ◯ Pregnancy _____

◯ Other _____

Have you ever undergone any surgeries? Please specify type and date.

_____

_____

Are you currently taking any medications? Please specify type and reason.

_____

_____

_____

_____

MEDICAL AUTHORIZATION

I _____ authorize THE PHYSIOTHERAPY PROFESSIONALS to obtain and review copies of my medical and/or vocational records, in order to assist me in my rehabilitation. I also consent to the release of such documents to THE PHYSIOTHERAPY PROFESSIONALS. A copy of this document is sufficient authority for doing so. I authorize THE PHYSIOTHERAPY PROFESSIONALS to release and and/or all information and documentation with regards to my treatment at this facility to other health care providers, insurance companies, or third parties.

_____ _____

Client Signature Date

Client Name _____ D.O.B _____

BILLING POLICY

Clients are responsible for payment of all goods and services rendered at THE PHYSIOTHERAPY PROFESSIONALS at the time of service. After client provides payment, a receipt will be issued. This receipt can be submitted to a private insurer, along with a completed claim form and doctor's referral for reimbursement.

It is the client's responsibility to submit their claim to their private insurance company for reimbursement of fees paid.

Failure to show for an appointment or canceling an appointment less than 24 hours in advance will result in a $30 cancellation fee.

I _____ have read the above and agree to the billing policy of THE PHYSIOTHERAPY PROFESSIONALS .

_____ _____

Client Signature Date

**Treating Therapist**

**Physiotherapist:**

| | | |
|---|---|---|
| Adam Keeping | Signature_____ | Date_____ |
| Charles Lorusso | Signature_____ | Date_____ |
| Tanya Tsui-Lorusso | Signature_____ | Date_____ |
| Andrew Kim | Signature_____ | Date_____ |
| Helen Suen | Signature_____ | Date_____ |

**Pelvic Floor Physiotherapist:**

| | | |
|---|---|---|
| Nelly Faghani | Signature_____ | Date_____ |
| Kathy Ng | Signature_____ | Date_____ |
| Kate McCormick | Signature_____ | Date_____ |

**Massage Therapist:**

| | | |
|---|---|---|
| Johnny Gallo | Signature_____ | Date_____ |
| Daniela Rapallo | Signature_____ | Date_____ |

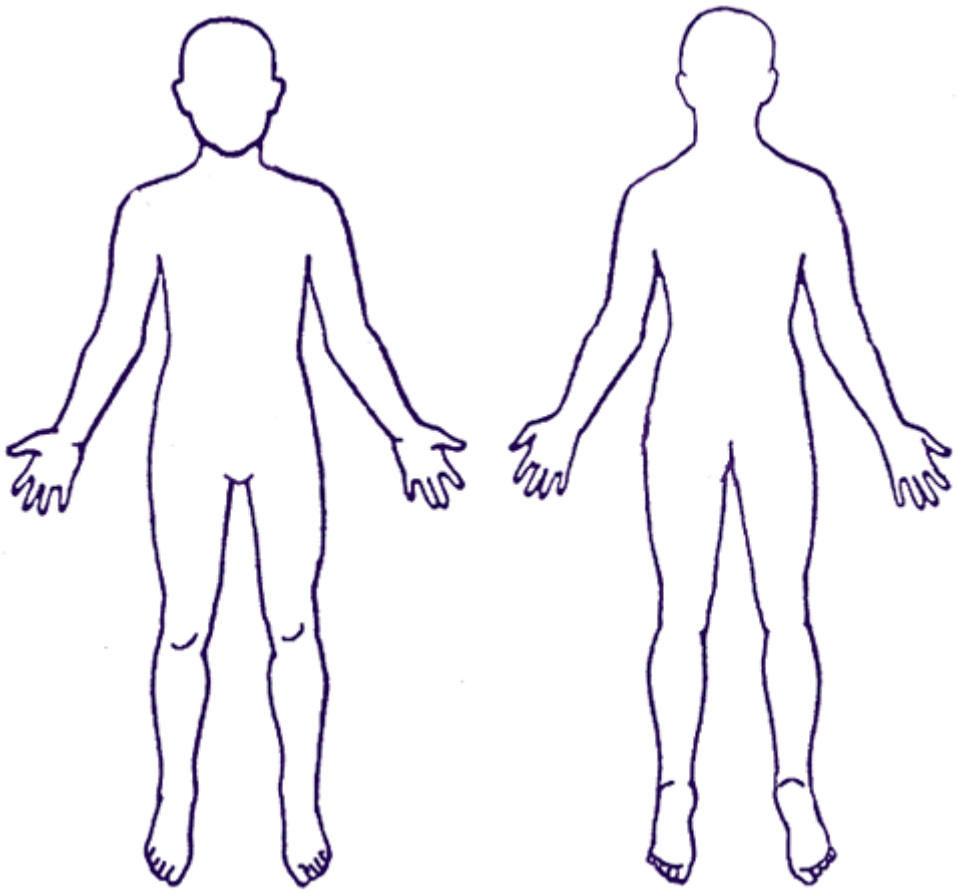
THE PHYSIOTHERAPY PROFESSIONALS

Client Name _____ D.O.B _____ Date:_____

Using the symbols given below, mark the areas on your body where you feel the described sensations.

Include all affected areas.

| Aching | Stabbing/Sharp | Numbness | Pins and Needles | Burning |
|---|---|---|---|---|
| Xxxxx | >>>>> | 00000 | ●●●●● | ///// |



FRONT BACK

Goals: please identify 2 goals you wish to achieve with your physiotherapy treatment:

1. _____
2. _____

Client Name _____ D.O.B _____

MEDICAL RECORDS

THE PHYSIOTHERAPY PROFESSIONALS is the Health Information Custodian (HIC). We are responsible for collecting, using, and disclosing your personal health information.

Responsibilities of HICs under the Personal Health Information Protection Act (PHIPA):

THE PHYSIOTHERAPY PROFESSIONALS will ensure that we will not collect, use or disclose personal health information unless:

- they have the individual's consent and the collection, use or disclosure is necessary for a lawful purpose; or
- the collection, use or disclosure is permitted or required by PHIPA;

THE PHYSIOTHERAPY PROFESSIONALS will take reasonable steps to safeguard personal health information, including:

- protecting against theft, loss and unauthorized use or disclosure;
- protecting against unauthorized copying, modification or disposal; and
- notifying an individual at the first reasonable opportunity if his or her personal health information is stolen, lost or accessed by unauthorized persons;
- taking reasonable steps to ensure that the personal health information they use is as accurate, complete and up-to-date as is necessary for the purposes for which they use or disclose it;
- ensuring that all personal health information records in their custody or control are retained, transferred and disposed of in a secure manner and in accordance with any prescribed requirements

I _____ have read the above understand the responsibilities of THE PHYSIOTHERAPY PROFESSIONALS as the Health Information Custodian of my personal health information.

_____ _____

Client Signature Date