



Name: _____
First Name Initial Last Name

Date: _____

Date of Birth (D/M/Y): ____/____/____

Marital Status: single married/common law widowed divorced

Home Mailing Address:

Street: _____ Box #: _____

Town: _____ Postal Code: _____

Home Phone Number: _____ Cell: _____

Email Address: _____

Consent to receive appointment reminders via email: _____

(Signature)

Occupation: _____

Employer: _____

Phone Number: _____

Do you have **Extended Health Benefits?** Yes No

Company (*Sun Life / GreenShield etc.*): _____

Policy Number: _____

Claim / ID Number: _____

Insured Members Name (if different than patient): _____ Date of Birth: _____

Is this a **Worker's Compensation Claim (WSIB)?**: Yes No

Date of Injury / Accident (D/M/Y): ____/____/____ Claim Number: _____

Name of WSIB Adjustor / Nurse Case Manager (if known): _____

Employer Contact Name: _____

Employer Address: _____

Is your injury due to a **Motor Vehicle Accident?** Yes No

Automobile Insurance Company: _____

Date of Accident (D/M/Y): ____/____/____ Claim Number: _____

Policy Number: _____ Policy Holder: Self Other: _____

Adjuster Name: _____

Adjuster Phone #: _____ Fax #: _____

Who referred you for Physiotherapy? _____

Family Physician: _____

Address: _____

Phone Number: _____

CURRENT MEDICAL CONDITIONS:

Reason for consulting this office?

What are your treatment goals or expectations from physiotherapy treatment?

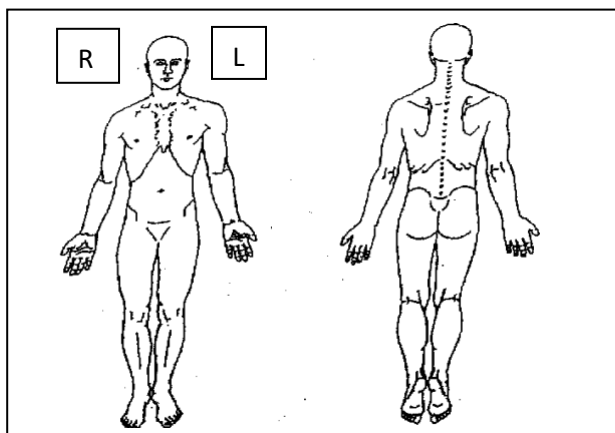
Are you currently pregnant or do you suspect you might be pregnant? Yes No

Do you have a Pace Maker: YES NO

PAIN DIAGRAM:

Please indicate on the diagrams (using the appropriate symbols) the area(s) of pain or unusual feelings.

Numbness: +++++
Pins and Needles: *****
Burning: xxxxxxx
Aching: //////////////
Stabbing: oooooo



MEDICATIONS:

Please list any medications you are currently taking (including birth control, aspirin)

PAST MEDICAL HISTORY:

Please check (✓) any condition that you have had in the past and circle any that are of present concern.

Aneurysm

Osteoporosis/osteopenia

If yes:

Most recent bone scan date: _____

T-score from bone scan: _____

Osteoarthritis

Stroke

Polio

Asthma

Rheumatoid arthritis

Hepatitis: A B C

Diabetes: Type 1 Type 2

Cancer: type _____

If yes, date of latest follow -up: _____

Thyroid Condition:

• Hyperthyroidism

• Hypothyroidism

Heart Attacks: Date? _____

Other: _____

Are you presently or have you taken any of the following for a prolonged period of time in the past?

Prednisone

Coumadin

Methotrexate

Amitriptyline

Warfarin

Thyrox

If yes to any of the above:

Duration of Use: _____

Date of last dose: _____

PHYSIOTHERAPY PAYMENT POLICY

Thank you for choosing Irwin Physiotherapy as your treatment facility. It is necessary that you be advised of and that you agree to the payment policy for our services before you begin treatment.

PAYMENT SOURCES:

Payment for physiotherapy services generally comes from the following sources:

- Extended Health Plans
- Motor Vehicle Insurance
- The Workplace Safety and Insurance Board (WSIB)
- Disability Insurance Plans
- Veteran's Affairs
- Direct payment from the employer
- Direct payment from the patient
- **Note: Physiotherapy treatments in this facility are NOT covered under the Ontario Health Insurance Plan (OHIP).**

FEES:

For private pay or extended health patients the fees are:

Initial Assessment and Report: \$80.00 / Initial Assessment for Concussions: \$100.00

Subsequent Treatments: \$50.00

WSIB and MVA fees are set by the respective institutions.

PAYMENT FREQUENCY:

For treatment that cannot be billed directly from this office, **payment is due at the end of each treatment session.**

PATIENT RESPONSIBILITIES

If these requirements are not fulfilled and a claim is denied, you will be responsible for payment of all services.

Customized Orthotics

We require a \$175 deposit before ordering your customized orthotics. This deposit will go towards the final price of the orthotics once they have been delivered to the clinic.

Extended Health Insurance

Please review your plan to ensure you have full understanding of the amount and type of coverage your plan offers. A physician's referral is *sometimes* required by the insurer before they will provide reimbursement.

Workplace Safety and Insurance Board

If you are submitting a claim through WSIB it is your responsibility to:

- ensure your employer and physician have completed and submitted all the necessary claim forms
- attend regular appointments with your physician as required by WSIB
- Complete all reports and forms (eg. Injured Worker Progress Notes and Physician Progress Note) that are requested by WSIB in a timely manner

Motor Vehicle Accident (MVA) Insurance

If you are submitting a claim through your motor vehicle insurance company it is your responsibility to:

- complete and submit all the necessary paperwork in the *Accident Benefits (AB) Package* that is supplied by your insurance company
- provide the clinic with extended health insurance claim forms (as requested by the clinic)
- deliver any cheques that are received from your extended health insurance company that are for physiotherapy services performed and billed by Irwin Physiotherapy
- Provide Irwin Physiotherapy with a copy of the *Explanation of Benefits* that accompanies the payment from your extended health insurance company.

No SHOW POLICY

- We request reasonable notice for any cancelled appointments
- **A fee of \$40.00 will be applied to your account for missed appointments.** A missed appointment is when no attempt is made by the patient to cancel the appointment before the scheduled appointment time
- 3 missed appointments will result in the patient discharge with no warning

I have read the above information and have a full understanding and agree to the above payment policies.

PATIENT SIGNATURE

DATE

Irwin Physiotherapy Privacy Policy

We value your business and thank you for your confidence in choosing our clinic as your Physiotherapy provider. You trust us with your personal information. We respect that trust and want you to be aware of our commitment to protect the information you share in the course of doing business with us.

How We Collect, Use and Disclose Your Information

When you attend for assessment or treatment from us, you share personal information so that we may provide you with products and services that best meet your needs. We assume your consent for our clinic to use this information in an appropriate manner. We may use and disclose this information in order to:

- 1) Ensure the assessing and treating practitioners can provide excellence in service provision by accessing all appropriate information when needed along a continuum of care.
- 2) Collect sufficient information to ensure that the service(s) provided will be paid for by the appropriate body(ies).
- 3) To advise clients, via email, of future appointment notifications
- 4) To advise clients and others of special events (e.g. a seminar, development of a new service, arrival of a new product).
- 5) Our clinic reviews client and other files for the purpose of ensuring that we provide high quality services, including assessing the performance of our staff.
- 6) All our Physiotherapists are regulated by the College of Physiotherapists of Ontario, who may inspect our records and interview our staff as a part of their regulatory activities in the public interest.

We Strive to Protect Your Personal Information

All employees and consultants who are granted access to customer records understand the need to keep this information protected and confidential. They know they are to use the information only for the purposes intended. This expectation is clearly communicated and violation of this trust will result in immediate termination of the service. We've also established physical and systems safeguards, along with the proper processes, to protect customer information from unauthorized access or use.

Your Privacy Choices

You may withdraw your implied consent at any time (subject to legal or contractual obligation and on providing us reasonable notice) by contacting our Privacy Officer. Please be aware that withdrawing your consent may prevent us from providing you with the requested product or service.

If You Need More Information

For more information about our privacy policies and procedures, please contact Irwin Physiotherapy's

Health Information Custodian (Craig Irwin) at 519-527-1551.



IRWIN PHYSIOTHERAPY INFORMED CONSENT FORM

CONSENT FOR TREATMENT

Patient Initials: _____

I, _____ hereby consent to assessment and treatment, including various physical modalities, manual therapy and an active exercise program.

I further understand and am informed that, as in all health care, there are some slight risks to treatment, including but not limited to, muscle strain, sprains, muscle soreness, disc injuries and strokes. I wish to rely on the physiotherapist to exercise judgment during the course of my rehabilitation which the physiotherapist feels, based upon the facts then known, is in my best interest.

I understand that any consent to treatment or to a portion of the proposed treatment plan can be voluntarily withdrawn without ramification.

CONSENT FOR PERSONAL INFORMATION

Patient Initials: _____

I understand that to provide me with physiotherapy treatment, Irwin Physiotherapy will collect some personal information about me. This includes home and work telephone number, address, date of birth, and if applicable, WSIB claim number, Extended Health Benefits information, Casualty or LTD Insurance information.

I have been provided the opportunity to review Irwin Physiotherapy's Privacy Policy about the collection, use and disclosure of personal information, steps taken to protect the information and my right to review my personal information. I understand how the Privacy Policy applies to me. I have been given a chance to ask any questions about the Privacy Policies and they have been answered to my satisfaction.

I understand that, as explained in the Policies and Procedures for Personal Information, there are some rare exceptions to these commitments.

I agree to Irwin Physiotherapy collecting, using and disclosing personal information about me as set out above and in the Privacy Policy.

CONSENT TO ALLOW USE OF SUPPORT PERSONAL Patient Initials: _____

I understand that to provide me with physiotherapy treatment, Irwin Physiotherapy utilizes support staff to provide me exercise instruction and administer ultrasound/IFC/heat to my affected areas.

Nicole Laprise, PTA is the support staff that assists with the provision of physiotherapy services at Irwin Physiotherapy. Nicole Laprise, PTA is trained in the application of therapeutic modalities and therapeutic exercises. Provision of this treatment is at the direction of and is supervised by Craig Irwin, PT / Megan Graham, PT.

I understand that any consent for use of support personnel can be voluntarily withdrawn without ramifications at any time during the treatment plan. _____

Patient Name (Please Print)

Date:

Patient Signature
Or Parent /Guardian Signature
(if patient is less than 16 years of age)

Signature of Witness:



INITIAL CONSULTATION FORM

DATE: _____

Patient consent for physical exam? Y N *MD report required?* Y N



PHYSIOTHERAPY TREATMENT SUMMARY SHEET

Medical Concern and Treatment Contraindications:

Initial Assessment Date: _____

Report Faxed / Mailed: _____

	Week 4:	Week 8:	Week 12:
Progress Note:			
Date Faxed / Mailed:			

Treatment Goals:

1. _____
2. _____
3. _____
4. _____

Functional Goals:

1. _____
2. _____

Outcome Measure Summary

Outcome Measure	Initial	Date	Date	Date	Date	Date

- Outcome measures are to be re-evaluated at the end of every 2nd week of treatment