CHIROPRACTIC *Health* CENTRE

Massage

An accurate health history ensures that it is safe for you to receive a massage treatment and helps the therapist determine a proper treatment plan. When your health status changes in the future, please let us know. All information gathered on this form is confidential. Your written authorization is legally requried before any of this information can be released.

Thank you for choosing our team. How did you find out about us? ______________________

Were you referred by a patient who has seen us? Who? ______________________

PERSONAL INFORMATION

Last Name: ______________________ First Name: ______________________ **M F N-B**

Phone: ______________________ (H) Address: ______________________

______________________ (W) Postal Code: ______________________

______________________ (C) Cellular provider: ______________ (for text reminders)

E-mail: ______________________ Reminder Pref.: Phone Text E-mail None

Would you like digital receipts? **Y N** Would you like to receive newsletter & updates via e-mail? **Y N**

Birthday: ______________________ (mm/dd/yyyy) Height: ______________ Weight: ______________

Occupation: ______________________ Emergency Contact: ______________________

Phone #: ______________________

HEALTH CLAIM INFORMATION

Would you like to use direct billing? **Y N** We offer direct billing for select insurance companies.

Please provide the following information:

______________________ Insurance Provider ______________ Annual limit ______________ Per visit limit

______________________ Name on Card ______________ Deductible ______________ Rollover date

______________________ ID #

______________________ Group/Policy/Contract#

Desjardins only allows for the plan member to receive reimbursement, therefore all fees incurred are still the patient's responsibility.

YOUR HEALTH HISTORY

Have you ever had a massage before? **Y N** If 'Yes', for relaxation or other? ______________________

Please list all medications you are currently taking (prescription & non-prescription): ______________________

____

Please list any surgeries, accidents and/or major illnesses and their dates: ______________________

Please list any other medical conditions (ex. haemophilia, diabetes...): ______________________

____

Have you had prior chiropractic care? **Y N** If 'Yes', Doctor's name: ______________________

Regular eating habits? **Y N** Do you suffer from stress? **Y N** Type: ______________

Regular exercise? **Y N** Do you use a computer? **Y N** Hours a day: ______________

Type/Frequency of exercise: Energy Level: High Average Low

____

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Massage

Please mark whether you have experienced any of the symptoms in the past and/or are presently:

GENERAL SYMPTOMS

Past	Present	
		Fainting
		Dizziness
		Loss of sleep
		Fatigue
		Nervousness
		Weight change
		Numbness
		Tingling
		Paralysis
		Headaches(tension)
		Migraines

CARDIOVASCULAR

Past	Present	
		High/low blood pressure
		Coronary artery disease
		Heart attack
		Phlebitis
		Stroke/CVA
		Pacemaker
		Heart murmur
		Palpitations
		Varicose veins
		Ankle swelling
		Poor circulation

INFECTIONS

Past	Present	
		Hepatitis
		Tuberculosis
		HIV
		Herpes
		Cold
		Flu
		Athlete's foot
		Warts

Other: ____________________

DIGESTIVE

Past	Present	
		Poor appetite
		Belching/gas
		Constipation
		Diarrhoea
		Nausea
		Ulcer
		Vomiting

EYE, EAR, NOSE, THROAT

Past	Present	
		Allergies
		Frequent colds
		Glasses/contacts
		Hearing aid
		Hearing loss
		Sinus infection
		Swollen glands

SKIN

Past	Present	
		Rashes
		Itching
		Bruise easily
		Dryness
		Boils

Other: ____________________

JOINT/SOFT TISSUE DISCOMFORT

Past	Present	
		Arms
		Upper back
		Mid back
		Lower back
		Degenerative discs
		Feet
		Hands
		Hips
		Jaw
		Shoulders
		Knees
		Legs
		Neck
		Sciatica
		Rheumatoid Arthritis
		Osteo Arthritis

Which joints? ____________________

RESPIRATORY

Past	Present	
		Chronic cough
		Bronchitis
		Asthma
		Hay fever
		Difficulty breathing
		Emphysema
		Smoker
		Pneumonia

WOMEN ONLY

Past	Present	
		Painful menstruation
		Heavy flow
		Irregular cycle
		Swollen breasts
		Menopausal
		Pre-menopausal
		Post-menopausal
		Pregnant

Weeks? ____________________

		Birth control

Type? ____________________

I attest that the information provided is true and complete to the best of my knowledge. I understand the information given is confidential and will not be released without my written consent. I consent to therapeutic massage therapy with Chiropractic Health Centre by a Registered Massage Therapist.

____________________ Signature of Patient (or Legal Guardian)

____________________ Printed name of Patient (or Legal Guardian)

____________________ Date

Ph: 403-277-9339
Fx: 403-277-2447

www.chiro-doctor.com

2713 Centre St NW
Calgary, AB T2E 2V5

Informed Consent for Massage Therapy

I hereby consent for my therapist to treat me with massage therapy for the above noted purposes including such assessments, examinations and techniques, which may be recommended, by my therapist.

I acknowledge that the therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that massage therapy is not a substitute for a medical examination. It is recommended that I attend my personal physician for any ailments that I may be experiencing. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge that with any treatment there can be risks and those risks have been explained to me and I assume those risks.

Risks of massage therapy vary with each patient's condition and the area being treated. Some risks may include:

Blood clots - patients with high blood pressure can have plaque growth on their arteries. Pressure exerted during massage may cause this plaque to rupture and cause a blood clot. Patients with deep vein thrombosis may also be at greater risk of massage releasing a blood clot.

Nerve damage - deep tissue massage exerts pressure to areas deep under the skin and too much pressure may result in nerve damage on some patients.

Infectious skin conditions - because of the skin contact between therapist and patient any infectious skin conditions must be discussed.

Patients should avoid massage if they have cancer, fractured or broken bones, blood clots, burns, lesions, certain forms of arthritis or osteoporosis, or certain skin conditions. It is advised that you speak to your medical doctor if you are experiencing any of these conditions before you see a massage therapist.

Some common side effects of massage therapy that may occur include temporary soreness or discomfort (similar to post-workout), bruising or swelling, sensitivity to some massage oils that are used.

I acknowledge and understand that the therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my therapist and disclosed to the therapist all of those medical conditions affecting me. It is my responsibility to keep the massage therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

I authorize my therapist to release or obtain information pertaining to my condition(s) and/or treatment to/from my other caregivers or third party payers.

I have read the above noted consent and I have had the opportunity to question the contents and my therapy. By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me and such additional treatment as proposed by my therapist from time to time, to deal with my physical condition and for which I have sought treatment. I understand that at any time I may withdraw my consent and treatment will be stopped.

____
Signature of Patient (or Legal Guardian)

____
Clinic staff witness signature

____
Printed name of Patient (or Legal Guardian)

____
Printed name

____
Date

All fees incurred for treatment are payable upon services rendered.
Fee schedule is as follows:

Chiropractic		**Massage**	
Initial Visit			
Adult	$109	30 Minute	$50
13-17 & 65+	$89	45 Minute	$68
12 & under	$74	60 Minute	$90
Shockwave	$175	90 Minute	$125
		120 Minute	$165
Subsequent Visits		Active Isolated Stretching	$165
Adult	$65		
13-17 & 65+	$50		
12 & under	$40		
Shockwave	$125	* All prices listed are excluding GST	
Re-examinations			
Adult	$80		
13-17 & 65+	$65	Hot Stone & Cupping: Regular massage plus $20	
12 & under	$55		
Additional Services			
Functional Integrated Acupuncture: Chiropractic treatment plus $25			

Cancellation Policy

Thank you for making us your choice in healthcare providers and we appreciate your consideration in respecting the needs of other clients by making any necessary cancellations within a timely manner. Our clinic does require 24 hours' notice for any appointment changes or cancellations. Any late cancellations or no shows will be billed for the full price of their office visit, including any patients that are unreasonably late for their appointment and require rescheduling. Please be aware that these fees will be your responsibility as they are not eligible for reimbursement through any health benefits providers. If care is suspended or terminated, any and all outstanding charges for professional services rendered to or for you will be immediately due and payable to the clinic.

Privacy Policies

We maintain a very high standard for the protection of the confidentiality and integrity of individual personal health information. If any identifying health information is to be released to us for the purposes of providing ongoing care; express written consent will be obtained. If it occurs that your health benefits service provider requires information regarding any of your appointments for any dates in the past, present or future Chiropractic Health Centre reserves the right to provide them with this information. If you have any questions regarding your privacy concerns, feel free to direct any inquiries to the front desk.

Email Communications

The use of email addresses is to only be used for birthday emails, appointment reminders and if it is a preferred method of contact or we are unable to reach you by phone. Newsletters and promotions will only be sent if authorized by yourself. Please note that at any time you may revoke your authorization for any of the above email communications.

Release of Receipts

I understand and acknowledge that receipts for service do contain some identifying information and hereby give my consent for the release of this information to myself via my chosen method, ie. printed or emailed. This is to include receipts for individual visits, as well as for any receipts required for tax purposes at year-end.

Photo Collection

The photos obtained at your initial visit are only for the use of identification purposes and the posture scans are for the purpose of charting your progress.

Re-examination

Please be aware that if you have not attended our clinic within the last **18 months** our chiropractors are required to perform a re-assessment. All associated fees are listed in the above fee schedule.

_______________________________ Signature of Patient (or Legal Guardian)

_______________________________ Printed Name of Patient (or Legal Guardian)

____________________ Date

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Electronic Transmission Authorization and Consent

Service Provider:
Chiropractic Health Centre

Consent for Collection and Disclosure of Personal Information

Personal information that we collect in regards to extended health care is disclosed solely for the purposes of determining eligibility and administering the benefits plan, this includes the investigation of fraud and/or plan abuse.

Authorization for the Release of Information

I confirm that I, if not the plan member, am authorized by the individual to release any information regarding them for the aforementioned purposes.

I permit Chiropractic Health Centre to collect, use, and disclose the necessary information needed in the processing of my extended health care claims.

In the event there is suspicion and/or evidence of fraud and/or plan abuse concerning any claims submitted I acknowledge and agree that my benefits provider and Chiropractic Health Centre may use and disclose any relevant personal information to each other for the purpose of investigation and prevention of fraud and/or plan abuse.

Assignment of Benefits

I agree to assign any benefits that are paid for my eligible claims to Chiropractic Health Centre and authorize my benefits provider to issue payment directly to them. In the event any submitted claim(s) are declined or only partially covered, I understand that I will remain responsible for the cost of the services rendered. If any outstanding balances occur from this and legal action becomes necessary to collect on this amount, I understand that I will be responsible for all attorney and legal fees incurred.

I understand the above terms and agree that this authorization is to apply to all eligible claim(s) submitted electronically by Chiropractic Health Centre, and that I may revoke authorization at any time by providing written notice.

I understand that providing my insurance information does not guarantee coverage and that any amount not covered is due upon services rendered.

I agree that a photocopy or electronic version of this authorization shall be as valid as the original, and may remain in effect for the continued administration of the group benefits plan.

______________________________ Signature of Patient (or Legal Guardian)

______________________________ Printed name of Patient (or Legal Guardian)

______________________________ Date