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**

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 newletter & updates via e-mail? **Y** **N**

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

Occupation: ______________________ Emergency Contact: ______________________

Phone #: ______________________

HEALTH CLAIM INFORMATION

Do you have extended health benefits? **Y** **N** We offer direct billing for select insurance companies.

Would you like to use direct billing? **Y** **N**

If 'Yes' please provide the following information:
You are encouraged to bring your insurance card with you to ensure we have the correct information.

______________________ Benefits Provider

______________________ Plan Member Name

______________________ ID #

______________________ Group/Policy/Contract#

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

____

CHIROPRACTIC *Health* CENTRE

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

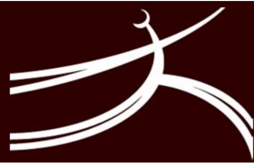
Type? ____________________

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.

____________________ Patient/legal guardian signature

____________________ Printed name

____________________ Date



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

Chiropractic	Massage	Acupuncture
Initial Visit	30 minute……$45	***Initial Visit***
Adult……$109	45 minute……$60	$135
65+ & 12-18……$89	60 minute……$80	***Subsequent Visits***
12 & under……$74	90 minute……$115	$90
Shockwave……$175	120 minute……$135	
Subsequent Visits	Active Isolated Stretch……$135	
Adult……$55		
65+ & 12-18……$44		
12 & under……$35		
Shockwave……$125		

Cancellation Policies

We appreciate your decision in making us your choice in health care, please respect the needs of our other patients and make any appointment cancellations in a timely manner. We require ***at least 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. This includes any patients that are unreasonably late for their appointment and need to be rescheduled. Please note that these fees will be your responsibility as they are not eligible for reimbursement through any health benefits provider. If care is suspended or terminated, any and all oustanding 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.

I have read and understand the above policies and procedures that are in place and agree to the terms that are defined.

I agree that a photocopy or electronic version of this authorization shall be as valid as the original.

______________________________ Patient/(Legal guardian) signature:

______________________________ Printed name

____________________ Date

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 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.

________________________________ Patient/legal guardian signature

________________________________ Printed name

____________________ Date

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PRINT **SAVE**