



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 required 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) _____ (W) _____ (C) Address: _____ Postal Code: _____

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**

Birth day: _____ (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



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



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



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