PATIENT INTAKE FORM

DUSK PHYSIOTHERAPY

Name: _____ M ☐ / F ☐ Date of Birth: _m__/_d__/__y__

Address: _____ Apt.____ City: _____ Postal Code: _____-_____

Home: (____) _____- _____ Cell: (____) _____- _____ Email: _____

Occupation: _____ Employer _____

Family Physician: Dr. _____ Permission to Consult? Yes ☐ No ☐

Physicians Phone No. (____) _____-_____ Address: _____

Main Interest For Today's Visit? ☐ Chiropractic ☐ Physiotherapy ☐ Massage ☐ Other _____

Therapy Goals: ☐ Pain Relief ☐ Flexibility ☐ Core Strength/Endurance ☐ Improve Posture ☐ Weight Loss ☐ Maintenance

1) Primary Insurance: _____ Group/Policy:_____ ID: _____

Policy Holder? ☐ Self ☐ Spouse ☐ Parent Name: _____ DOB: _m__/_d__/__y__

2) Secondary Insurance: _____ Group/Policy:_____ ID: _____

Policy Holder? ☐ Self ☐ Spouse ☐ Parent Name: _____ DOB: _m__/_d__/__y__

Auto Accident Information

Insurance: _____

Claim No. _____ Accident Date _m__/_d__/__y__

Adjustor Name: _____

(P) _____ (F) _____

WSIB Information

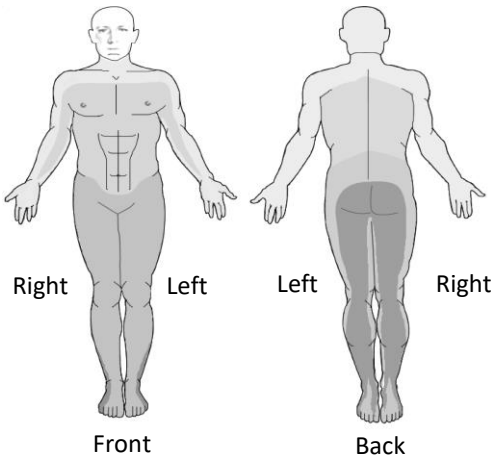
Is This a New Injury Claim? Yes ☐ No ☐

Claim No. _____Accident Date _m__/_d__/__y__

Adjustor Name: _____

(P) _____ (F) _____

In the diagram and using the symbols below mark the areas on your body that you feel best represents the location and type of pain or sensation you are **currently** experiencing.



0 ——————— 10

Place a vertical mark along the line to indicate your level of pain (0 being the least pain and 10 being the worst pain)

Tight/Stiff (**X**) Sharp (**/**)
Burning (**O**) Numbess (●)

Use the symbols above to indicate the type of pain or sensation you are currently experiencing

Please check the following health conditions/procedures that apply to **you**, both past (X) and present (✓)

☐ Abdominal Pain	☐ Headache/Migraine	☐ Muscle Cramps/Spasm	☐ Scoliosis
☐ Arthritis	☐ Heart Disease/Attack	☐ Neck Pain/Stiffness	☐ Sciatica
☐ Chronic Pain	☐ Hyper/Hypo-Tension	☐ Numbness/Tingling	☐ Spinal Cord Injury
☐ Diabetes	☐ Joint Pain/Stiffness	☐ Osteoporosis	☐ Sprain / Strain
☐ Fatigue/Weakness	☐ Kidney Problems	☐ Poor Circulation/Bruising	☐ Stroke/Aneurysm
☐ Fracture	☐ Low Back Pain	☐ Rheumatoid Arthritis	☐ Thyroid Disease
☐ Sensitivities/Allergies	☐ Loss of Sensation	☐ Cancer	☐ Pacemaker
☐ Ear Problems	☐ Vison Loss/ Problems	☐ Varicose Veins/Phlebitis	☐ Other _____

Infections: ☐ Hepatitis ☐ Skin Condition ☐ TB ☐ HIV ☐ Herpes ☐ Other Gynecological Infections _____

Respiratory: ☐ Chronic Cough ☐ Shortness of Breath ☐ Bronchitis ☐ Asthma ☐ Emphysema

Are you pregnant? ☐ No ☐ Yes How far along? _____ How is your general Health? _____

Do you take any medications? No ☐ Yes ☐ _____

Surgery History? _____

Please check the health conditions that you apply to your **immediate family**, both past (X) and present (✓)

☐ Cancer _____	☐ Diabetes _____	☐ Stroke/Aneurysm _____
☐ Heart Disease _____	☐ Cholesterol _____	☐ High Blood Press. _____
☐ Respiratory Problems _____	☐ Arthritis _____	☐ Other _____

Clinic Policy Agreement

General Policy

Dusk Physiotherapy ensures a fair and professional relationship toward all our patients, and we ask that as a patient that you be considerate to the doctors, therapists, administration staff and fellow patients while attending our facility.

Information/Record Keeping Policy

Dusk Physiotherapy requires certain information as it relates to your current condition and health history. All information provided will be kept strictly confidential, which includes all medical and health information and well as any personal and financial information that may be provided.

Cancellation Policy

Dusk Physiotherapy enforces a strict cancellation policy to ensure that any given patient can receive the care they need on any given day. We require **24-hour** notice for cancellation of any appointment. A fee of **$50** will be charged for missed appointments without **24-hour** notification. This fee is not covered by insurance plans and thus must be paid at the patient's own expense.

I have read, understand and agree to the clinic policy's set forth by Dusk Physiotherapy to the best of my knowledge, I certify that the information provided in the above forms is accurate and that I will advise Dusk Physiotherapy staff of any changes to my personal information or health history.

_____	_____	_____
Patient Signature or Parent/Legal Guardian	Patient Name or Parent/Legal Guardian (Printed)	Date (m/d/y)

Payment Agreement

☐ Pay As You Go:
The patient will pay for services and/or products provided by Dusk Physiotherapy. Invoices and receipts will be provided to the patient and the patient will be responsible for submitting claims to their insurance for reimbursement. *(no credit card information required on file)*

☐ Direct Billing: (Extended Health Care/ Motor Vehicle Accident /WSIB)
The patient allows Dusk Physiotherapy to submit claims directly to insurance companies on their behalf, provided electronic submission is available under the insurance policy. Payment will be assigned directly to the clinic (if applicable) and any unpaid balances (i.e) deductibles, co-pays, exhausted coverage limits, or non-eligible services/products) will be the responsibility of the patient. To ensure full payment is received by the clinic, a valid credit card is required on file to collect unpaid balances in part or in full by your insurance provider(s). Claims submission will be facilitated by Dusk Physiotherapy and all insurance and financial information provided will be encrypted and kept strictly confidential.

CREDIT CARD INFORMATION

_____ - _____ - _____ - _____	_____	_____ / _____	_____
Credit Card Number	*Type*	*Expiry Date (m / yy)*	*3 digit CSC code*

I have read and/or have been explained the payment options available to me, including all financial terms and conditions set out by Dusk Physiotherapy and agree to abide by them. I understand that payment is expected in full for all services/products provided and I allow Dusk Physiotherapy to charge my credit card for any unpaid balances on my account. Receipts will be provided to me for any charges incurred on my credit card and I may at any time request invoices for any services/products that have been provided.

_____	_____	_____
Patient Signature or Parent/Legal Guardian	Patient Name or Parent/Legal Guardian (Printed)	Date (m/d/y)