pt Health

Personal Information

Last Name: | First Name: | Middle Initial: | DOB (mm/dd/yyyy):

☐ Check here if all the information in this section has not changed since your last visit. Please proceed to the next section.

Home Address: | Street: | Apartment Number:

City: | Province: | Postal Code:

Email Address: | Primary Phone #: | Alternate Phone #:

Health Card Number: | Health Card Expiry (if applicable, mm/dd/yyyy):

Emergency Contact Person: | Relationship: | Primary Phone #:

Referral

Family Doctor: | Referring Physician: ☐ Same as Family Doctor | Nurse Practitioner (if applicable):

What were you referred for? (Check all that apply)

☐ Physiotherapy ☐ Massage Therapy ☐ Chiropractic ☐ Naturopathy ☐ IMS/Acupuncture
☐ Psychology ☐ Hand Therapy ☐ Orthotics ☐ Occupational Therapy ☐ Other

If other, please specify:_____

Have you ever been treated previously on the same injury:_____

Were you admitted to the hospital for your injury? ☐ Yes ☐ No If yes, which hospital?_____

How did you hear about our clinic?

☐ Website ☐ Yellow Pages ☐ Events ☐ Promotion ☐ Doctor Referral
☐ Social Media ☐ Search Engine ☐ Poster/Flags ☐ Family/Friend ☐ Internal Referral

Coverage Type

☐ No Coverage | ☐ Extended Health Benefits (Complete section below) | ☐ Government Funding (OHIP/MSP/AHS) | ☐ Motor Vehicle Accident (MVA/MVC) (Complete Additional Insurance Page, Section B) | ☐ Workplace Injury (WCB/WSBC/WSNB/WSIB) (Complete Additional Insurance Page, Section C)

Extended Health Benefits Information (for secondary plan, please complete Additional Insurance Page, Section A)

Name of Insurance Company: | Name of Policy Holder (☐ Self): | Policy Holder DOB (mm/dd/yyyy):

Policy Holder's Relationship to Patient: | Policy / Claim No.: | ID / Certificate / Perm No.:

Name of Employer:

pt Health

Name of Patient: _____ Date of Birth: (mm/dd/yyyy): _____

Additional Insurance Information

Coverage Type

☐ Secondary Extended Health Benefits (Complete Section A)
☐ Motor Vehicle Accident (MVA/MVC) (Complete Section B)
☐ Workplace Injury (WCB/WSBC/WSNB/WSIB) (Complete Section C)

A) Secondary Extended Health Benefits Information (if applicable)

Name of Insurance Company: Name of Policy Holder: Policy Holder Date of Birth (mm/dd/yyyy):

Policy Holder's Relationship to Patient: Policy / Claim No.: ID / Certificate / Perm No.:

Policy Holder Employer:

B) Motor Vehicle Accident Insurance Information (if applicable)

Name of Insurance Company: Name of Policy Holder: ☐ Same as patient Policy Holder Date of Birth (mm/dd/yyyy):

Policy Holder Relationship to Patient:

Date of Accident (mm/dd/yyyy): Policy Number: Claim Number:

Name of MVA Adjuster: Adjuster Phone: Adjuster Fax:

Adjuster Email:

Have you completed the initial paperwork sent by your insurance company? ☐ Yes ☐ No

C) Work Injury Information (if applicable)

Date of Injury (mm/dd/yyyy): Claim Number:

Name of Employer: Employer Phone: Employer Fax:

Address of Employer (street, city, postal code):

Name of Case Manager: Phone: Fax:

Have you completed the initial paperwork when reporting the injury at work? ☐ Yes ☐ No

pt Health Patient Consent

Use of Personal Information

pt Health collects, uses, discloses, retains and disposes of your personal information in compliance with federal and provincial privacy legislation and applicable college regulations. All staff members who come in contact with your personal information have signed a confidentiality form and have been trained in the appropriate use and protection of your information. If you have any questions, please contact the pt Health Privacy Officer at 1-866-749-7461 or via email at privacyofficer@pthealth.ca. We use and disclose your personal information in the following ways:

- To assess your health concerns, advise you of options and provide healthcare
- To communicate with other treating healthcare providers, including your physician
- To obtain diagnostic test results pertinent to the condition for which you are seeking treatment
- To allow us to efficiently follow-up for treatment, care and billing via phone, email, addressed mail and voicemail
- To establish and maintain contact with you
- To complete claims for insurance purposes
- To invoice for goods and services
- To collect unpaid accounts and process credit card payments
- To comply with the law
- To contact you from time to time during treatment and post-treatment about new services, changes to services, special offers, surveys, clinic updates and other opportunities, by phone, email or addressed mail and voicemail

☐ I would like to receive email reminders of my appointments

Financial Responsibility

pt Health will bill your insurance carrier on your behalf when we can verify that payment will be received by the clinic directly.

In the following circumstances you will be responsible to pay *at the time of service or product purchase*:

- When you do not have any insurance that will cover the product or service
- When your insurance carrier sends payment directly to you or requires that you pay and submit your expenses
- When your coverage does not pay 100% or has been used up (you are responsible for the copayment)
- When a product is custom made (deposit is required before ordering)

In the following circumstances you can provide your credit card information and carry an outstanding balance:

- If you have an approved car insurance claim and your extended health benefits are paid to you directly (we will bill your credit card if the payment has been confirmed and it has remained outstanding for a period of 30 days) *
- If you start treatment before getting approval for a car insurance or work injury claim (if your claim gets rejected, we will notify you and bill your credit card once the remaining balance is outstanding for a period of 30 days) *

*Please bring to the clinic copies of paperwork you receive from any of your insurance companies

Consent for Assessment & Treatment

I give my consent to undergo assessment and treatment. I have had the chance to discuss with my healthcare provider(s) the risks and benefits for my particular condition. My treatment may include: manual therapy, modalities (e.g. heat, ice, whirlpool, contrast bath, wax, laser, ultrasound, interferential current (IFC), electrical muscle stimulation, TENS, mechanical traction, acupuncture, dry needling, intramuscular stimulation, cupping, spinal manipulation), and active exercise. I understand that results are not guaranteed and that I may withdraw this consent at any time. If deemed appropriate by my therapist, I agree to have a student or support personnel carry out my treatment plan under supervision.

_____ Clinician Initials - Consent Confirmed After Assessment

Cancellation Policy

We appreciate 24 hours advance notice for any cancellations and reserve the right to charge a cancellation fee if not adhered to.

I have read the above details and give my informed consent below.

Name of Patient:

_____

Signature of Patient (or Guardian):

_____

Patient Date of Birth: (MM/DD/YYYY):

_____

Date of Signature (MM/DD/YYYY):

_____