RETURN PATIENT PHYSIOTHERAPY FORM

Today's Date: ___________________________________

PERSONAL INFORMATION: **PLEASE PRINT CLEARLY**

Name (first/last): ____ Middle Initial: ___________

Date of Birth: __________________ Age: _______ Sex: _________ Sask Health Card #: ______________________

Home Phone #: ___________________ Cell #: _____________________ Work #: ____________________________

Emergency Contact (Name and Phone #): ____

Please fill out any contact information below that may have changed since your last visit.

Address: ____ City: ______________________________________

Prov: ___________ Postal Code: _____________________ Email: _____________________________________

You can opt to receive emails/texts to keep you informed of new bookings, changes to existing appointments and reminders for upcoming appointments. Please initial the communication you would like to receive:

_____ Emailed notification of new bookings/changes to appointments

_____ Emailed reminders 24 hours prior to appointments

_____ Text reminders 24 hours prior to appointments

_____ Please do not send me any emails/text messages

NO SHOW/LATE CANCELLATION POLICY: As a courtesy to other clients, Chiropractors, and other providers, I understand that I must give **3 hours' notice** if I cannot make it to my scheduled appointment. Stonebridge Chiropractic will charge me for **missed appointments at the rate of the scheduled visit, billed directly to me**, and is payable prior to my next visit. SGI, WCB and other insurers do not cover the cost of missed appointments. Please help us serve you better by keeping scheduled appointments. __________ **(Initial)**

INSURANCE POLICY: I am aware that it is my responsibility to check with my insurance company and its policies regarding provider and therapist requirements before receiving treatments from any provider at Stonebridge Chiropractic. Stonebridge Chiropractic is not responsible for any treatments not covered by my insurance. **I have read, understood, and agree to the above financial policies.** __________ **(Initial)**

Patient Signature: ____ **Date:** ______________________

PLEASE CONTINUE ON OTHER SIDE →

PATIENT HEALTH SCREEN

Are your present symptoms or conditions related to/caused by (circle)?

Car Accident   Work Injury   Sudden Trauma   Repetitive Trauma   Unknown/Gradual

What areas of your body are painful or dysfunctional, and require assessment?

____

____

____

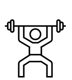
- Has your doctor ever said you have heart trouble? ☐ Yes ☐ No
- Do have frequently have pains in your heart or chest? ☐ Yes ☐ No
- Do you ever feel faint or have spells of severe dizziness? ☐ Yes ☐ No
- Have you ever had a seizure? ☐ Yes ☐ No
- Have you ever been told your blood pressure is too high? ☐ Yes ☐ No

Please list your medical conditions and past surgeries:

____

____

List all the PRESCRIBED medications you are taking	Dosage	Prescribing Physician name

 What are the activities that you do for fun and fitness?

____

____

____

If there is any other information that you would like your Physiotherapist to know prior to beginning the assessment, please include it here.

____

____

STONEBRIDGE CHIROPRACTIC

CONSENT TO PHYSIOTHERAPY

Use of Personal Information and Provision of Physiotherapy Services

The purpose for the collection, use or disclosure of your personal information is to provide informed physiotherapy assessment and treatment. It also assists with the establishment of your claim for compensation or benefits.

Limits to Confidentiality

The Physiotherapist may disclose your personal information, including your personal health information, without your consent, or if you have withdrawn your consent, where permitted or required by law to do so. For example:

- If there is reason to believe you are dangerous to yourself or others.
- If there is reason to believe that dependents have been or may be abused or neglected.
- If there is a medical emergency.
- If there is a court order asking for information about your involvement with Stonebridge Chiropractic Health Clinic.
- If you have been referred to, assessed, or treated at Stonebridge Chiropractic for a work-related injury (i.e. through WCB funding); or
- As otherwise required by law.

Disclosure

You agree and authorize the Physiotherapist to communicate with the agencies or individuals listed below. The Physiotherapist will only discuss information that relates to your assessment and treatment plan. If you are working with a team of clinicians at Stonebridge Chiropractic, your team members will share your information with each other as needed.

______________________________	______________________________
Doctor or Primary Health Care Practitioner	Insurance Company
______________________________	______________________________
Employer	Lawyer/Personal Representative
______________________________	______________________________
Other (please specify)	Other (please specify)

PLEASE CONTINUE ON OTHER SIDE →

Acknowledgement and Consent

I, understand that my participation with the Physiotherapist at Stonebridge Chiropractic Health Centre is voluntary and my consent is required to collect, use or disclose my personal information and personal health information, and for the Physiotherapist to provide assessment and treatment.

I have read and fully understand and agree with the statements above. I consent to the collection, use and disclosure of my personal information and personal health information. I further consent to the Physiotherapist providing me with the assessment, treatment and/or other services related to my injury or illness, and/or my claim for compensation or benefits. The benefits, risks and results will be explained to me by my Physiotherapist. I understand that I will be afforded the opportunity to ask my Physiotherapist any questions I may have regarding my assessment and treatment, and to express any concerns I may have.

I understand that I have the right to refuse or withdraw my consent in whole or in part at any time, on reasonable notice to the Physiotherapist. If I withdraw my consent, I understand that this is not retroactive, and does not apply to personal or personal health information that has already been collected, use, or disclosed by the Physiotherapist.

Patient Name (please print): ____

Patient Signature: ____ Date Signed: _________________________

Signature of Parent or Guardian (if under the age of 18): ____

Signature of Physiotherapist: _______________________________ Date Signed: _________________________