

## PATIENT REGISTRATION FORM

### PATIENT INFORMATION

Last Name: \_\_\_\_\_ First Name and Initial(s): \_\_\_\_\_ Gender:  M  F Date of Birth (yyyy-mm-dd): \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Email: \_\_\_\_\_

*By providing your email, you are consenting to email communication from Rebalance Sports Medicine such as appointment reminders, statements, invoices, exercise instructions & commercial electronic messages.*

Health Card #: \_\_\_\_\_ Version Code: \_\_\_\_\_ Expiry Date (yyyy-mm-dd): \_\_\_\_\_

Phone (Home): \_\_\_\_\_ Phone (Work): \_\_\_\_\_ Phone (Mobile): \_\_\_\_\_

Please indicate the best method of contact during the day:  Home  Work  Mobile

Emergency Contact (Name and Phone): \_\_\_\_\_

### MEDICAL INFORMATION

Family Physician Name: \_\_\_\_\_ Physician Phone: \_\_\_\_\_

Physician Address: \_\_\_\_\_

### HOW DID YOU HEAR ABOUT US?

Website  Street Signage  Doctor's Referral \_\_\_\_\_  
 Google  Return Patient  Family/Friend Referral \_\_\_\_\_  
 Twitter  Yelp  Local Businesses \_\_\_\_\_  
 Facebook  Yellow Pages  Other \_\_\_\_\_

*(Rebalance Sports Medicine respects your privacy. We do not sell, rent, loan or transfer any personal information regarding our clients to any third parties.)*

## CONFIDENTIAL HEALTH SCREENING QUESTIONNAIRE

*(The health information requested on the following form will assist us in treating you safely. If you have any questions about the requested information, please feel free to ask.)*

Primary reason for your visit?

Do you currently have or have previously had any of the following conditions?

- |                                    |   |   |                                    |
|------------------------------------|---|---|------------------------------------|
| <input type="checkbox"/> Diabetes  | <input type="checkbox"/> Skin Conditions  | <input type="checkbox"/> Gynecological Conditions | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Cancer    | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Stroke/CVA               | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Lung Conditions  | <input type="checkbox"/> Broken Bones             | <input type="checkbox"/> Other     |
| <input type="checkbox"/> HIV/AIDS  | <input type="checkbox"/> Epilepsy         | <input type="checkbox"/> Kidney Problems          | _____                              |
| <input type="checkbox"/> Asthma    | <input type="checkbox"/> Osteoporosis     | <input type="checkbox"/> Heart Disease            | _____                              |

Current Medications:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Drug Allergies:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

For Women:

- |                                |                              |                             |
|--------------------------------|------------------------------|-----------------------------|
| 1. Have you given birth?       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Have you had a C-Section?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Are you currently Pregnant? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Have you had any surgeries? Please provide details.

Do you currently (or within the past year) have any of the following symptoms?

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Chest Pain          | <input type="checkbox"/> Vomiting/Nausea        | <input type="checkbox"/> Unexplained Weight Change         |
| <input type="checkbox"/> Heart Palpitations  | <input type="checkbox"/> Difficulty Swallowing  | <input type="checkbox"/> Loss of Balance/Co-ordination     |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Speech Disturbances    | <input type="checkbox"/> Weakness in Arms and Legs         |
| <input type="checkbox"/> Dizziness/Blackouts | <input type="checkbox"/> Fevers/Chills/Sweats   | <input type="checkbox"/> Numbness in any part of your Body |
| <input type="checkbox"/> Loss of Appetite    | <input type="checkbox"/> Unrelenting Night Pain | <input type="checkbox"/> Urinary/Bowel Problems            |

Please tell us what your three (3) primary goals are or what you wish to achieve at Rebalance?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

## INFORMED CONSENT FOR ASSESSMENT AND TREATMENT

### PLEASE READ CAREFULLY

I understand that assessment and treatment at Rebalance Sports Medicine may include, but is not limited to: exercise prescription, manual therapy techniques (such as mobilizations, manipulations, soft tissue release and stretches) and therapeutic modalities (such as heat, ice, electrical stimulation, ultrasound, laser and shock wave therapy). Other treatment options include acupuncture/dry needling that involves the insertion of disposable and sterile needles through the skin into targeted tissue structures.

It is the policy of Rebalance Sports Medicine to ensure each patient is educated about the benefits, side effects, and potential complications of each treatment option used by our therapists. I understand that the primary goals of my treatments are to help reduce my pain, improve my mobility, strength, endurance, my overall functioning and quality of life.

I understand that there are very small possibilities of risks or complications that may result from the above listed treatments. I do not expect the therapist to anticipate all the possible risks and complications. I rely on my therapists' judgment to make decisions based on my best interests.

### POTENTIAL SMALL BUT POSSIBLE RISK FACTORS

**Manual Therapy:** Joint and/or muscle soreness

**Exercise Therapy:** Joint and/or muscle soreness

**Electrical Modalities:** Minor skin irritations such as redness or rash

**Therapeutic Taping:** Minor skin irritations such as redness or rash

**Acupuncture/Dry Needling:** Minor soreness, bleeding, bruising, nausea, fainting, headache, infection, possible perforation of internal organs and stimulation of labour in pregnant women

I will immediately notify my therapist of any changes in my pregnancy or medical status.

I will have the opportunity to discuss with my therapist, the nature and purpose of all my treatments and I accept the fact that there is no guarantee to the effectiveness of the treatment. I am aware that I may withdraw this consent and discontinue my treatment at any time.

I consent to the assessment and treatment offered to me by my therapist. I intend this consent to apply to all my present and future care at Rebalance Sports Medicine. I consent that the health records collected at Rebalance Sports Medicine will be available to all health providers involved in my circle of care. *(For more information about your health records please ask to view our Privacy Policy).*

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Patient Name (print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Witness Name (print)

## PAYMENT AGREEMENT FORM

### PAYMENT POLICY & INSURANCE COVERAGE

**Therapy Services:** Physiotherapy, Massage Therapy, Chiropractic, Acupuncture, Bracing and Orthotics are covered by most extended health care plans. Each plan can be variable with respect to amount covered per treatment and the annual limits. As the policy holder, it is **your responsibility** to contact your insurance company and determine the exact details of your coverage.

**Medical Services:** Sports Medicine consultations are covered by Ontario's Health Insurance Plan (OHIP). However, many administrative services and some medical procedures are deemed by OHIP to not be medically necessary and are therefore uninsured. It is Rebalance Sports Medicine's policy that these services are billable directly to the patient and payment is due on receipt of the service. Please refer to our "Uninsured Medical Services and Pricing List" for more details.

Payment for services is due in full by **Cash, Debit or Credit Card** at the end of each treatment session. A receipt with all of the required information will be provided to you so that you can submit it to your insurance company for re-imburement. If you qualify for direct billing, you will only be required to pay any co-payments or deductibles not covered by your plan.

### CANCELLATION POLICY

We require a **minimum of 24 hours notice** for change or cancellation of any appointment. This will allow us to fill the available time slot with another patient who needs our services. Your account will be charged the full treatment fee if you cancel with less than 24 hours notice or if you do not show up for your appointment.

Should you arrive late for your appointment or request to leave early, the full fee for the appointment time you have booked will also apply.

**Please Note:** We understand that your time is valuable and therefore make every effort to keep our schedule running on time. Due to the nature of our work, unexpected delays sometimes occur. Please be assured that under these circumstances you will still receive your full treatment time. Thank you for helping us to maintain a high level of service for all of our clients.

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**I fully understand the above and agree to abide by these policies:**

\_\_\_\_\_  
Patient or Guardian/Parent Signature

\_\_\_\_\_  
Date