fix HEALTHCARE

Acupuncture Intake

Date: ____ Sex: M F Other ________________

Name: ____

Care Card #: ____

Birthdate (mm/dd/yyyy):_________________________________ Age:___________

Address: ____City:____________________ Province: _______ Postal Code:___________

Home Phone: _________________________Work Phone: ________________________ Cell Phone:________________________________

Our software can send you reminder emails 2 days prior to your appointment and/or a text message 24 hours prior to your appointment.

How would you like to receive your appointment reminders? → □ Text: (please be sure to include your cell phone number above)

□ Email: ____

□ No reminders

Medical Doctor Name: ____

Occupation ____ Employer____

Who referred you to this clinic? Google/Drove By/Friend/Fix Healthcare Sign/Other____

Have you ever received Acupuncture before? Yes No

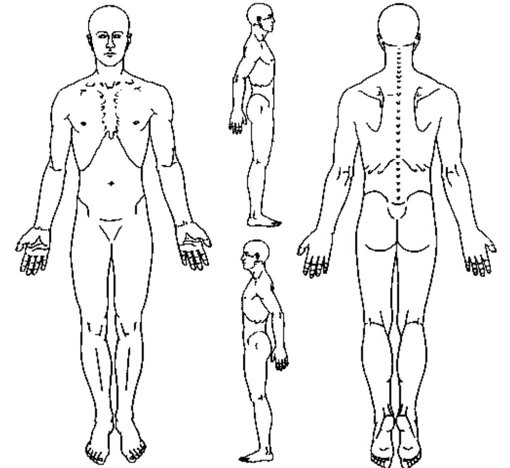
Reasons for seeking Acupuncture & Chinese Medicine:

Primary Reason: ____

Secondary Reason: ____

Location of Complaint: (Use drawings on the right)

A = ACHE	**C= CRAMPS**
P = PINS & NEEDLES/ TINGLING	**ST= STIFFNESS**
B = BURNING	**S = STABBING/SHOOTING**
N = NUMBNESS	**O = OTHER**



Complaint began when & how? ____

Intensity/Severity: (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst pain imaginable)

Does anything aggravate this condition? ____

Does anything relieve this condition? ____

Does this condition interfere with: (circle) Work Daily Routine Exercise Sleep

Rate the following 1(poor) to 5 (excellent): _____ Sleep Patterns _____ Eating Habits

_____ Exercise Habits _____ Water Consumption

What treatments have you tried? (circle) Chiropractic Medical Doctor Massage Therapy

Physiotherapist Naturopath Other _______________

INFORMED CONSENT FOR ACUPUNCTURE TREATMENTS

I hereby request and voluntarily consent to receive treatments of acupuncture and Chinese Medicine procedures for my present and future health conditions. I understand that treatment will be administered by a Registered Acupuncturist (R. Ac.) at Fix Healthcare.

Acupuncture treatments that may be administered:

Acupuncture: A treatment involving the insertion of thin sterile disposable needles through the skin, which can produce a mild but temporary discomfort at the acupuncture site. It can occasionally cause slight bleeding and will rarely leave a bruise. Other possible risks from acupuncture include dizziness and fainting. The patient should report to the R.Ac any dizziness or light-headedness that occur during or after an acupuncture treatment. Extremely rare risks of acupuncture (these have an extremely low incidence, especially when acupuncture is administered properly) including nerve damage, organ puncture and infection.

Cupping: A localized suction produced by heating a small glass cup. There is a possibility of local bruising from the suction. Extremely rare is a slight burn or blister due to the heat.

Tui-Na: A Chinese Massage technique that uses pressing, rubbing, kneading and pinching to bring the body back into balance. Tui-Na is applied to channels, collaterals and acupuncture points. Manipulating the body using Tui-Na locally promotes blood accumulation and removes blood stasis.

Heat Treatment with a TDP lamp: A warming method using an infrared heat lamp on a specific area of the body. Every precaution is taken to prevent over warming, but the rare possibility of mild burns exist.

Electrostimulation: A mild electric micro-current (similar to a TENS treatment) is used to stimulate the acupuncture points. A mild tingling or tapping sensation will be felt.

I have had the opportunity to discuss with the acupuncturist the nature and purpose of treatments under Chinese Medicine. I understand that results are not guaranteed. I understand that only sterile disposable needles will be used during my treatments. All acupuncture needles will be properly disposed of after each and every treatment. I further understand and am informed that the practice of acupuncture poses slight risks from treatment, including but not limited to temporary soreness, bruising, blistering, nausea, fainting, bleeding, infection and shock. I do not expect the acupuncturist to be able to anticipate and explain all risks and complications and I wish to rely on the acupuncturist to exercise judgment during the course of the procedure which the acupuncturist feels at the time based upon the facts then known in the best of my interests.

By signing below I show that I have read the information on this consent form. I understand the possible risks and complications involved. I have had the opportunity to discuss this consent form with my Registered Acupuncturist. I understand that I can request more information at any time if desired. I consent to receive treatment that involves the above procedures. I understand that I have the right to refuse or discontinue treatment at any time. I understand that this refusal may affect the expected results.

In consideration of other patients and other practitioners, a minimum of 24 hours' notice is required to change or cancel appointments. This time has been reserved for you and unattended appointments prevent practitioners from seeing other patients. Patients will be expected to cover the full treatment fee in the case of missed appointments or late cancellations that cannot be booked by another patient. Please be advised that non-attended appointments cannot be billed to insurance providers. Thank you for your consideration.

If I am using my extended benefits, I authorize Fix Healthcare to direct bill on my behalf and receive payment for my treatments directly. I agree that I will be responsible for any fees which are not covered by my insurance, including those which may be initially accepted but later refused by my insurance.

______________________	______________________	____________	______________________
Print Patient Name	Signature of Patient (or guardian)	Date	Signer for Fix Healthcare

Assignment of Medical Services Plan Benefits to Opted-Out Practitioner

I, ____ (beneficiary) authorize the Medical Services Plan to pay my Practitioner directly for all reimbursements for benefits payable to me under the Medical and Health Care Services Regulation for care provided to me by said Practitioner.

I make this assignment in full knowledge of the amount that I will be personally responsible for the patient portion of the fee and the amount that is reimbursable by the Medical Services Plan ($23.00). The amount reimbursed by MSP will be directed to the Practitioner checked above and be applied against any outstanding monies I owe for services provided. This form allows the practitioner to receive your MSP reimbursement directly for services that are MSP benefits. Our practitioner, by law, must advise you of his/her full fee and what portion will be reimbursed by MSP. By agreements, your practitioner may not charge you the portion reimbursable by MSP.

I understand that any appointments I receive over and above the 10 subsidized treatments per year will be my responsibility to pay at the private fee rates.

Patient's Name: ____ (please print) Care Card Number (PHN): ______________________

Signature:____ Date:____

MEDICAL HISTORY

Please check any of the following that have ever affected you and indicate date

□ Addiction________
□ AIDS
□ Alcoholism
□ Anemia
□ Appendicitis
□ Arteriosclerosis
□ Arthritis
□ Asthma
□ Breast Lumps
□ Breathing Problems
□ Bronchitis
□ Cancer
□ HIV Positive
□ Candida
□ Chicken Pox
□ Chronic Fatigue
□ Colitis/IBS
□ Diabetes
□ Digestive Disorders
□ Eating Disorder
□ Hepatitis
□ Emotional Imbalance
□ Emphysema
□ Epilepsy
□ Hypotension
□ Food, Chemical Poisoning
□ Fibromyalgia
□ Gall Stones
□ Glaucoma
□ Goiter
□ Gout
□ Heart Disease
□ Hernia
□ Nephritis
□ Herpes
□ High Cholesterol
□ Hypertension
□ Rheumatism
□ Kidney Stones
□ Malaria
□ Measles
□ Meningitis
□ Mononucleosis
□ Multiple Sclerosis
□ Mumps
□ Ulcers
□ Neuralgia
□ Paralysis
□ Prostate Problems
□ Scarlet Fever
□ Seizures
□ Stroke
□ STD__________
□ Thyroid Problems
□ Tonsillitis
□ Tuberculosis
□ Typhoid Fever
□ Elevated Liver Enzymes
□ Urinary Problems
□ Whooping Cough
□ Bursitis
□ Other: __________

Surgeries, Hospitalizations and Significant Trauma's (auto accidents, falls, loss of loved ones, etc).

Date ________________________ Event ____

________________________ ____

________________________ ____

________________________ ____

________________________ ____

Allergies

____

____

____

____

Chinese Medicine – Symptomology

Please mark the following symptoms that you currently have.

General:

□ Fatigue
□ Insomnia
□ Disturbed Sleep
□ Frequent Dreams
□ Alternating Fever & Chills
□ Dislike Cold
□ Dislike Heat
□ Weight Loss
□ Weight Gain
□ Unusual Daytime Sweating
□ Chills
□ Edema or Swelling
□ Night Sweats
□ Fever
□ Other: ________________
□ Usually Thirsty
□ Seldom Thirsty
□ Excessive Sleep

Skin:

□ Rashes
□ Hives
□ Acne
□ Easily Bruised
□ Changes in Lumps/Moles
□ Unusual Bleeding
□ Other: _____________

Head & Neck:

□ Dizziness
□ Jaw Pain
□ Other: ___________
□ Headaches: __________

Eyes & Ears:

□ Failing Vision □ Blurred Vision □ Visual Spots □ Night Blindness □ Eye Pain/Swelling
□ Ringing in the Ears □ Ear Pain □ Ear Discharge □ Other: _______________

Nose/Throat/Mouth:

□ Nose Bleeds □ Sore throat □ Hoarseness □ Tooth or Gum Pain □ Nasal Discharge/Infection
□ Frequent Sneezing □ Bleeding Gums □ Other: ___________ □ Difficulty Swallowing □ Change in sense of taste
□ Change in Sense of Smell □ Mouth/Tongue Ulcers

Muscles & Joints - Pain, weakness or numbness in:

□ Hips/Leg/Feet □ Hot Joints □ Body Pain □ Muscle Cramps □Neck/Shoulder/Arm/Head
□ Swollen Joints □ Heavy Limbs □ Other: ____________ □ Sore Low Back & Knees

Nervous Systems:

□ Fainting □ Paralysis □ Tremors □ Poor Balance □ Seizures
□ Other: _______________

Heart, Lungs & Chest:

□ Palpitations □ Chest Pain □ Tightness □ Rapid Heart Beat □ Irregular Heart Beats
□ Cough □ Dry Cough □ Frequent Colds □ Asthma/Wheezing □ Swelling of the ankles
□ Coughing up Blood □ Shortness of Breath □ Coughing up Phlegm □ Pain in Rib Cage □ Other: ________________

Mental/Emotional:

□ Poor Memory □ Worry □ Anxiety □ Depression □ Difficulty Concentrating
□ Frustration or Anger □ Fearfulness □ Stress □ Irritability □ Other: _______________

Digestive System:

□ Nausea □ Diarrhea □ Loose Stool □ Hemorrhoids □ Vomiting Food
□ Constipation □ Stomach Pain □ Bloody/Black Stool □ Vomiting Blood □ Other: _______________

Urinary/Genital:

□ Incontinence □ Painful Urination □ Difficult Urination □ Cloudy Urine □ Frequent Daytime Urination
□ Bloody Urine □ Genital Pain/Itch □ Low Sexual Drive □ Excessive Sexual Drive □ Frequent Night Urination
□ Genital Discharge (Lesions) □ Painful Intercourse □ Other: _______________

Male:

□ Impotence □ Weak Urinary Stream □ Prostate Hypertrophy □ Premature Ejaculation □ Seminal Emissions
□ Other: _____________

Female:

□ Irregular Periods □ Painful Periods □ No Periods □ Scanty Periods □ Menopausal Symptoms
□ Passing Clots □ PMS □ Breast Lump □ Early Periods □ Breast Pain & Discharge
□ Abnormal PAP smear □ Bleeding Between Periods □ Other: _____________

Hospitalizations: (Please note if you have ever been hospitalized and why)

____

____

____

____

____

Medications:

NAME	DOSAGE

Supplements:

NAME	DOSAGE

Health Habits:

Substance	x	How much do you use or consume how often
Sugar		
Caffeine		
Tobacco		
Alcohol		
Recreational Drugs		
Other		

Diet: Describe your diet in general terms. Number of meals per day, how often you eat out, dietary restrictions, favorite flavors & foods.

____
____
____
____

Do you exercise regularly? **Yes** □ **No** □
Describe:

____
____
____
____

______________________________ ______________________________ ____________________
Patient Name (Please Print) Patient Signature Date

Benefit Assignment &
Electronic Transmission Authorization and Consent Form

Provider:

Fix Healthcare Downtown
805 Johnson Street
Victoria, BC V8W 1N4
P: 250-385-5583

Fix Healthcare Selkirk
2958 Jutland Road
Victoria, BC V8T 5K2
P: 778-265-9555

Instructions: This form must be filled out when claim payment is assigned to the Provider and claims are submitted electronically by the provider on the patient's behalf.

If you have coverage under more than one insurance company, we may be able to direct bill for both. Please write down the details of your PRIMARY insurance here, and tell reception about your secondary insurance.

Name I've used for my Fix Healthcare patient file: ____

Name that is on my insurance plan (if different from above): ____

Birthdate (mm/dd/yyyy): ____

Address: ____

City/Province: ____

Postal Code: ____

Phone Number: ____

Please circle your insurance company:

Plan Number: ______________________________ Certificate / ID #: ______________________________

Select One

☐ I am the **PRIMARY** member on this plan

☐ This is my **PRIMARY** insurance, but I am a spouse/dependent/child/partner/other:
Name of the primary insured member on the plan: ______________________________
Primary's birthdate (mm/dd/yyyy): ______________________________

Optional

☐ I also have **SECONDARY** insurance with this company: ______________________________
(Please check with reception for whether or not we can bill to this insurance for you as well)

Please turn over the page, read, and sign the consent form: →

Benefit Assignment I hereby assign benefits payable for the eligible claims to the Provider responsible for submitting my claims electronically to the group benefits plan and I authorize the insurer/plan administrator to issue payment directly to the Provider. In the event my claim(s) are declined by the insurer/plan administrator, I understand that I remain responsible for payment to the Provider for any services rendered and/ or supplies provided.

I acknowledge and agree that the insurer/plan administrator is under no obligation to accept this Assignment, that any benefit payment made in accordance with this Assignment will discharge the insurer/plan administrator of its obligations with respect to that benefit payment, and that in the event the benefit payment is made to me, the insurer/ plan administrator will also be discharged of its obligation with respect to that benefit payment.

I understand that this Assignment will apply to all eligible claims submitted electronically by the Provider and that I may revoke it at any time by providing written notice to the insurer/plan administrator. If I am a spouse or dependent, I confirm that I am authorized by the plan member to execute an assignment of benefit payments to the Provider.

Consent to Collect and Exchange Personal Information (Message to the Plan member, Spouse and/or Dependent regarding Personal Information) Personal information that we collect and disclose about you, and if applicable, your spouse and/or dependents, is used by the insurer and/or plan administrator and their service provider(s) for the purposes of assessing your claims, underwriting, investigating, auditing and administering the group benefits plan, including the investigation of fraud and / or plan abuse.

Authorization and Consent I authorize my healthcare provider to collect, use and disclose personal information concerning any claims submitted on my behalf with the insurer and/or plan administrator and their service provider(s) for the above purposes. I authorize the insurer and / or plan administrator and their service provider(s) to:

- use my personal information for the above purposes.
- exchange personal information with any individual or organization, including healthcare professionals, investigative agencies, insurers and reinsurers, and administrators of government benefits or other benefits programs when relevant for the above purposes.
- exchange personal information concerning any claims submitted with the plan member or a person acting on behalf of the plan member.
- exchange personal information for the above purposes electronically or in any other manner.

I understand that personal information may be subject to disclosure to those authorized under applicable law. 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.

Additional Consent Applicable to Plan Members Only I confirm that I am authorized by my spouse and/or dependents, if any, to disclose personal information about them to the insurer and/or plan administrator and their service provider(s) for the purposes described above and I confirm that my spouse and/or dependents also authorize the insurer and/or plan administrator and their service provider(s) to disclose information about their claims to me, for the purposes of assessing and paying a benefit, if any, and managing the group benefits plan. I also authorize my spouse and/or dependents to assign benefit payments under the plan to the healthcare provider.

In the event there is suspicion and/or evidence of fraud and/or plan abuse concerning claims submitted, I acknowledge and agree that the insurer and/or plan administrator and their service provider(s) may use and disclose relevant personal information to any relevant organization including law enforcement bodies, regulatory bodies, government organizations, medical suppliers and other insurers, and where applicable my Plan Sponsor, for the purposes of investigation and prevention of fraud and/or plan abuse.

If there is an overpayment, I authorize the recovery of the full amount of the overpayment from any amount payable under the group benefits plan, and the exchange of personal information with other persons or organizations, including credit agencies and, where applicable, my Plan Sponsor, for that purpose.

Date: ______________________ Print Name: _________________________ Signature: ___________________________