Chiropractic Intake

Name _____ Sex: M F Other:_____ Date_____

Care Card # _____Date of Birth (mm/dd/yyyy)_____ Age_____

Address_____City_____ Province_____ Postal Code _____

Home Phone _____Work Phone _____ Cell Phone_____

Would you like appointment reminders? → □ Email _____ □ Text □ No reminders

Medical Doctor_____ Who referred you to this clinic? Google/Drove By/Friend/Fix Healthcare Sign/ Other _____

Is this an ICBC claim? Would you like us to do direct billing for you (ICBC/Lawyer?) Y / N Claim #: _____

Injury Date: _____ Adjustor's name: _____ Adjustor's direct phone #: _____ Lawyer (if applicable):_____

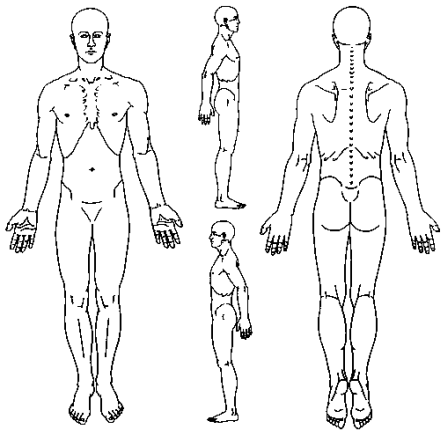
Who did you see for the first treatment after your injury? (name / occupation): _____

Please note that we do not accept WCB claims. Please notify reception immediately if you have come in for treatment for a workplace injury.

What is the reason for your visit? (please draw the location of your complaint on the picture as well) _____

What treatment have you tried for this, including medications?

_____



When did this condition start? _____

Has it occurred before? YES / NO

How did it happen? _____

Is it related to job or auto accident? JOB AUTO No

What makes it feel worse? _____

What makes it feel better? _____

Since it started, is it getting better or worse? Better / Worse

What is the severity 0 to 10 (0= No Pain and 10 = Worst)? _____ Does the pain shoot or travel? YES / NO Where? _____

How often does the pain occur? _____ How long does the pain last? _____

CURRENT HEALTH & INJURIES

Any Motor Vehicle Accidents? YES / NO What? Dates? _____

Any Work Injuries? YES / NO What? Dates? _____

Any Sports Injuries? YES / NO What? Dates? _____

Have you ever injured your head or lost consciousness? YES / NO

Is the reason for this visit also worsening your sleep? YES / NO

Have you seen a chiropractor before? YES / NO Whom? _____ When?_____ Why?_____

Have you had X-rays taken for your area of complaint? YES / No When? _____Where?_____

Past Hospitalizations or major illness: _____

Surgeries and operations:_____

Are you on any medications/vitamins/over the counter drugs/birth control? _____

Any allergies? _____

Over →

Do you have a family history of? Heart Problems Cancer Diabetes

(please circle) High Blood Pressure Stroke Back/Neck Pain

Do you smoke or chew tobacco? Yes, I currently smoke ____ pack(s) / day, and have for _____ years.

(Please circle & fill in) No, but I used to. Quit how long ago? _____ How much did you smoke then? _____

Never.

Do you have interrupted sleep? It has been interrupted_____ times/night for _____ months/years.

YOUR HEALTH HISTORY Have you experienced any of the following? (Please check all that apply)

- ☐ Fever / chills
- ☐ Recent weight loss or gain
- ☐ Anemia
- ☐ Fatigue
- ☐ Bleeding abnormalities
- ☐ Night sweats
- ☐ Limitation of movement, where _____
- ☐ Headaches, type _____
- ☐ Heart disease, heart attack
- ☐ High or low blood pressure
- ☐ High or low cholesterol
- ☐ Changes in vision, hearing, smell, or taste
- ☐ Persistent cough
- ☐ Difficulty breathing
- ☐ Frequent infections
- ☐ Chest pain
- ☐ Stroke
- ☐ Cancer
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Dizziness
- ☐ Seizures, fainting, epilepsy
- ☐ Insomnia
- ☐ Depression
- ☐ Anxiety
- ☐ Phlebitis
- ☐ Varicose veins
- ☐ Diabetes
- ☐ Pregnancy (past/currently)
- ☐ Menstrual problems
- ☐ Constipation
- ☐ Gastrointestinal problems
- ☐ Blood in urine or stool
- ☐ Kidney or bladder problems
- ☐ Psoriasis
- ☐ Contagious skin condition
- ☐ Allergies, type _____
- ☐ HIV / AIDS / Hepatitis
- ☐ Swollen joints
- ☐ Spinal curvature / scoliosis
- ☐ Numbness or weakness

Is there anything else not covered here that the doctor should be aware of? NO / YES (Write below)

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:_____

fix HEALTHCARE

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

It is important for you to consider the benefits, risks and alternatives to the treatment options offered by your chiropractor and to make an informed decision about proceeding with treatment. Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body, soft-tissue techniques such as massage, and other forms of therapy including, but not limited to, electrical or light therapy & exercise.

Benefits: Chiropractic treatment has been demonstrated to be effective for complaints of the neck, back and other areas of the body caused by nerves, muscles, joints and related issues. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility, improve function, and reduce or eliminate the need for drugs or surgery.

Risks: The risks associated with chiropractic treatment vary according to each patient's condition as well as the location and type of treatment. The risks include:

- **Temporary worsening of symptoms**: Usually, any increase in pre-existing symptoms of pain or stiffness will only last a few hours to a few days.

- **Skin irritation or burn**: Skin irritation or burn may occur in association with the use of some types of electrical or light therapy. Skin irritation should resolve quickly. A burn may leave a permanent scar.

- **Sprain or strain**: Typically, a muscle or ligament sprain or strain will resolve itself within a few days or weeks with some rest, protection of the area affected and other minor care.

- **Rib fracture**: While a rib fracture is painful and can limit your activity for a period of time, it will generally heal on its own over a period of several weeks without further treatment or surgical intervention.

- **Injury or aggravation of a disc**: Over the course of a lifetime, spinal discs may degenerate or become damaged. A disc can degenerate with aging, while disc damage can occur with common daily activities such as bending or lifting. Patients who already have a degenerated or damaged disc may or may not have symptoms. They may not know they have a problem with a disc. They may also not know their disc condition is worsening because they only experience back or neck problems once in a while. Chiropractic treatment should not damage a disc that is not already degenerated or damaged, but if there is a pre-existing disc condition, chiropractic treatment, like many common daily activities, may aggravate the disc condition. The consequences of disc injury or aggravating a pre-existing disc condition will vary with each patient. In the most severe cases, patient symptoms may include impaired back or neck mobility, radiating pain and numbness into the legs or arms, impaired bowel or bladder function, or impaired leg or arm function. Surgery may be needed.

- **Stroke:** Blood flows to the brain through two sets of arteries passing through the neck. These arteries may become weakened & damaged, either over time through aging or disease, or as a result of injury. A blood clot may form in a damaged artery. All or part of the clot may break off & travel up the artery to the brain where it can interrupt blood flow & cause a stroke. Many common activities of daily living involving ordinary neck movements have been associated with stroke resulting from damage to an artery in the neck, or a clot that already existed in the artery breaking off & travelling up to the brain. Chiropractic treatment has also been associated with stroke. However, that association occurs very infrequently, & may be explained because an artery was already damaged and the patient was progressing toward a stroke when the patient consulted the chiropractor. Present medical & scientific evidence does not establish that chiropractic treatment causes either damage to an artery or stroke. The consequences of a stroke can be very serious, including significant impairment of vision, speech, balance & brain function, as well as paralysis or death.

Alternatives: Alternatives to chiropractic treatment may include consulting other health professionals. Your chiropractor may also prescribe rest without treatment, or exercise with or without treatment.

Questions or Concerns: You are encouraged to ask questions at anytime regarding your assessment and treatment. Bring any concerns you have to the chiropractor's attention. If you are not comfortable, you may stop treatment at any time. Please be involved in and responsible for your care. Inform your chiropractor immediately of any change in your condition.

- I hereby acknowledge that I have discussed with my chiropractor the assessment of my condition and the treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I hereby consent to chiropractic treatment as proposed to me.

- In consideration of other patients and my practitioner, I understand that 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 online 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 initially be accepted but later refused by my insurance.

- DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR -

Name (Please Print)	Signature of patient (or legal guardian)	Signature of Chiropractor	Date

fix HEALTHCARE

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:

Chambers of Commerce Group Insurance Plan® · CINUP · Cowan · First Canadian Insurance Corporation · Manulife Financial For your future® · the co-operators A Better Place For You®

INDUSTRIAL ALLIANCE Insurance and Financial Services Inc. · JOHNSON · JOHNSTONGROUP · MAXIMUM Benefit · gsc green shield canada · GroupHEALTH Benefit Solutions · Group Source

MANION · THE Great-West Life ASSURANCE COMPANY · Sun Life Financial · PACIFIC BLUE CROSS · MEDAVIE BLUE CROSS

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: _____