fix HEALTHCARE

RMT 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:______________

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

□ Email: ______________________

Medical Doctor Name: ______________________

Occupation ______________________ Employer______________________

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

Is this an ICBC claim? Claim #: ______________________ Injury Date (mm/dd/yyyy): ______________________

Would you like us to direct bill ICBC for your claim? Y / N Adjustor's name: ______________ Adjustor's ph #: ______________

Are we to direct bill your lawyer? Y / N Lawyer's name/office: ______________ Lawyer's ph #: ______________

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

Please note that we do not direct bill WCB for any services.

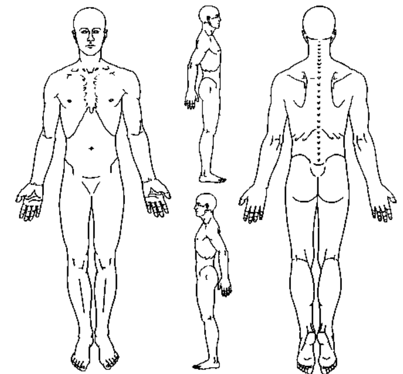
Have you ever received Massage Therapy? Yes No

Reasons for seeking Massage Therapy:

Primary Reason: ______________________

Secondary Reason: ______________________

Please mark the areas on the diagram where you feel any symptoms:



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 Acupuncture Physiotherapist Naturopath

Other: ______________________

Please list and date any injuries/surgeries/other medical conditions:______________________

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What medications you are taking?______________________

Have you experienced any of the following? (check all that apply)

- ❑ Limitation of movement, where ________________
- ❑ Headaches, type ______________________
- ❑ Heart Disease
- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Stroke
- ❑ Cancer
- ❑ Arthritis
- ❑ Osteoporosis
- ❑ Dizziness
- ❑ Fatigue
- ❑ Insomnia
- ❑ Depression
- ❑ Altered Sensation
- ❑ Bleeding Disorders
- ❑ Phlebitis
- ❑ Varicose Veins
- ❑ Diabetes
- ❑ Pregnancy (past/currently)
- ❑ Menstrual problems
- ❑ Constipation
- ❑ Gastrointestinal Problems
- ❑ Hernia
- ❑ Eczema
- ❑ Psoriasis
- ❑ Contagious skin condition
- ❑ Allergies, type ______________________
- ❑ HIV/Aids
- ❑ Swollen joints
- ❑ Spinal Curvature
- ❑ Epilepsy

Please fill out this consent if you are eligible for Premium Assistance and would like us to bill on your behalf:

Assignment of Medical Services Plan Benefits to Opted-Out Practitioner

I, ____ (*print name please*) 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.**

Care Card # (PHN): ________________________ Signature:_________________________ Date: __________________________

- PLEASE DO NOT SIGN THIS NEXT PART UNTIL YOU MEET WITH YOUR RMT-

It is important for you to consider the benefits, risks and alternatives to the treatment options offered by your RMT and to make an informed decision about proceeding with treatment. Massage treatment can include soft-tissue techniques such as manual massage, instrument-assisted massage, assisted stretching, and other forms of therapy including heat and cold and prescriptive exercises. You are encouraged to ask questions at any time regarding your assessment and treatment. Bring any concerns you have to your RMT'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 RMT immediately of any change in your condition.

In consideration of other patients and your practitioner, 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 using your extended benefits, you authorize Fix Healthcare to direct bill online on your behalf and receive payment for your treatments directly. You agree to be responsible for any fees which are not covered by your insurance, including those which may initially be accepted but later refused by your insurance.

Your healthcare records will be kept by Fix Healthcare on behalf of your practitioner in accordance with BC law (FIPPA & PIPA).

I hereby acknowledge that I have discussed with my massage therapist the assessment of my condition and the treatment plan. I understand the nature of the treatment to be provided to me. I hereby consent to massage treatment as proposed to me.

____ ____________________________

Patient Signature **Date**

(MASSAGE THERAPIST TO COMPLETE) INITIAL ASSESSMENT NOTES:

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Benefit Assignment & Electronic Transmission Authorization and Consent Form

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