Physiotherapy 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: _____

□ No reminders

Medical Doctor Name: _____

Occupation _____ Employer_____

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#_____

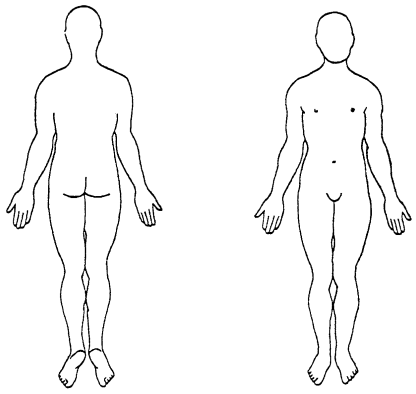
Injury Date _____ Adjustor's name_____ Adjustor's # _____ Lawyer (if applicable) _____

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.

Describe the nature of your current symptoms, and mark on chart areas affected:

_____



How & when did your symptoms start? _____

Have you had this issue before? Y / N When: _____

Is your family physician aware? Y / N

Are your symptoms getting better / worse / same since this started? (please circle)

Have you had any testing (x-ray, MRI, CT, any other tests) taken for your area of complaint? Y / N

When: _____

What makes your symptoms better? _____

What makes your symptoms worse? _____

Using the 0 to 10 the scale, with 0 being *"no pain"* and 10 being the *"worst pain imaginable"* please describe:

My current pain level is: _____ In the last 24 hours, the best my pain has been is: _____ & the worst it has been is: _____

List any and all medication that you have been taking, including vitamins and over the counter medications: _____

_____

Have you in the past or are you currently taking blood thinning medications/anticoagulants? Y / N

Please list any allergies: _____

Please list any and all surgeries and/or hospitalizations you have had in the past:

_____

_____

_____

(Please turn page and complete reverse) →

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

- ❑ Fatigue
- ❑ Fever/chills/sweats
- ❑ Painful intercourse
- ❑ Nausea/vomiting
- ❑ Weight loss/gain
- ❑ Fainting / Falls
- ❑ Vision Changes
- ❑ Numbness or tingling
- ❑ Muscle weakness
- ❑ Heart palpitations
- ❑ Dizziness/lightheadedness
- ❑ Heartburn/indigestion
- ❑ Pain with deep breath
- ❑ Headaches
- ❑ Constipation
- ❑ Diarrhea
- ❑ Swollen ankles
- ❑ Shortness of breath
- ❑ Dental abscess/surgery
- ❑ Cough
- ❑ Difficulty swallowing/speaking
- ❑ Throbbing or pulsating pain in abdomen
- ❑ Changes in bowel or bladder function
- ❑ Increase in pain with eating
- ❑ Pain with bending/twisting
- ❑ Difficulty with balance while walking
- ❑ Changes in urine color/odor/flow/clarity

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- ❑ Cancer
- ❑ Heart problems
- ❑ Chest pain/angina
- ❑ High/low blood pressure
- ❑ Lung problems
- ❑ Tuberculosis
- ❑ Asthma
- ❑ Stroke
- ❑ Thyroid problems
- ❑ Diabetes
- ❑ Bladder/urinary tract infection
- ❑ Kidney problem/infection
- ❑ Liver problems
- ❑ Hepatitis type A/B/C
- ❑ Drug/alcohol dependency
- ❑ Pneumonia
- ❑ Depression
- ❑ Anxiety
- ❑ Rheumatoid arthritis
- ❑ Other arthritic condition
- ❑ Osteoporosis
- ❑ Anemia
- ❑ Autoimmune disease
- ❑ Ulcers
- ❑ Pelvic inflammatory disease
- ❑ Circulation problems
- ❑ Epilepsy
- ❑ Multiple sclerosis
- ❑ Bone or joint infection
- ❑ Sexually transmitted infection/HIV
- ❑ Eye problem/infection
- ❑ Bleeding abnormalities

If cancer, what type of cancer and what treatments have you had: _____

Other conditions not listed above: _____

Are you a smoker? Y / N Do you have a pacemaker? Y / N Are you pregnant? Y / N

During the past month have you been feeling down, depressed or hopeless?	Y / N
During the past month have you been bothered by having little interest or pleasure in doing things?	Y / N
Is this something with which you would like help?	Y / N / Yes but not today
Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way?	Y / N

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 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 be initially accepted but later refused by my insurance.

_____ _____

Patient Signature Date

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, _____ (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 # (PHN): _____

Signature:_____ Date:_____

Physiotherapist Intake

Date:_____

Patient:

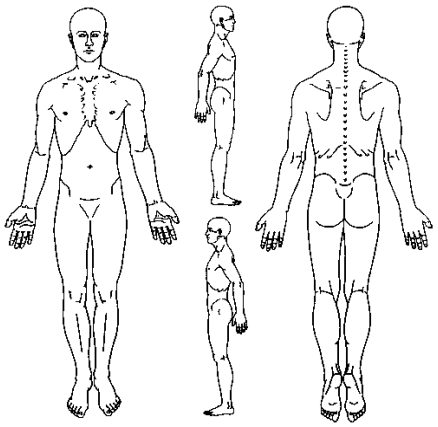
Occupation:

Therapist:_____

Is this a WCB or ICBC claim?

Parasthesia: + -

Sites of Pain & Paraesthesia



Current History:

PMHx:

Pain Behaviour:

Aggravated By:

Relieved By?

Headaches:

AM:

PM:

Night Waking:

Sleeping Position:

Cough/Sneeze:

General Health: HBP / LBP / Ca / Pacemaker

Medications:

X-Rays:

Special Questions:
Bowel & Bladder:
Dizziness / Nausea:
Weight Loss:
Bilateral Paraesthesia:

Observation:

Passive Physiological and Accessory Movements:

Active Movements:

Ligament / Joint Stability Tests:

Resisted Movements:

Other Tests:

Myotomes:

Dermatomes:

Reflexes:

Palpation:

Plantar Response:

Clonus:

Nerve Root Tension:

Treatment:

Analysis:

Plan:

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: _____