Patient Information

Welcome

Here's what you can expect on your first visit:

1. You will provide us with your health information
2. The Patient Coordinator will introduce you to your Doctor or Therapist
3. Your Doctor or Therapist will assess you
4. Your Doctor or Therapist will explain your treatment plan
5. You will schedule your treatments and referrals with the Patient Coordinator
6. The Patient Coordinator will present any recommended rehab devices and/or healthcare aids

Personal

☐ All the information in this section has not changed since my last visit. Please proceed to the Referral Section below.

Last Name | First Name | Initial

Home Address | Street | Apartment No.

City | Province | Postal Code

Email Address | Home Phone | Phone: ☐ Cell ☐ Work

Date of Birth (mm/dd/yy) | Health Card No.

Emergency Contact Person | Relationship | Phone

Referral

Family Physician | Referring Physician ☐ Same

What were you referred for? Check **all** that apply

☐ Physiotherapy ☐ Massage Therapy ☐ Chiropractic ☐ Naturopathic ☐ IMS / Acupuncture

☐ Psychology ☐ Hand Therapy ☐ Orthotics ☐ Occupational Therapy ☐ Other

Were you admitted to the hospital for your injury? ☐ Yes ☐ No Which hospital?

How did you hear about our clinic? Check **all** that apply and circle the primary source

☐ Website ☐ Doctor ☐ Return Patient ☐ Friend / Family ☐ Yellow Pages

☐ Google ☐ Bing ☐ Location ☐ Employer ☐ Other

Coverage

☐ No Coverage ☐ Benefits ☐ Motor Vehicle Accident (MVA) ☐ OHIP ☐ Workplace Injury (WSIB)

Insurance/Benefits if applicable

Date of Injury (mm/dd/yy) | Policy/Claim No. | Name of Policy Holder | Policy Holder's Date of Birth (mm/dd/yy)

Name of Insurance Company | ID / Certificate / Perm No.

Name of Employer | Job Title | Phone | Fax

Name of Adjudicator | Phone | Fax

Address of Adjudicator | Street | Unit No.

City | Province | Postal Code

Have you been treated previously for injuries sustained? ☐ Yes ☐ No

For MVA only Have you completed Accidents Benefits Package (if applicable)? ☐ Yes ☐ No

Health

1. What is your primary complaint (or body part) that you are seeking treatment for today? _____

2. Do you presently or have you ever had any of the following? Check **all** that apply

- ☐ Pacemaker
- ☐ Heart Problems
- ☐ High Cholesterol
- ☐ Stroke
- ☐ Lung Problems
- ☐ Cancer
- ☐ Diabetes
- ☐ Osteoporosis / Osteopenia
- ☐ High Blood Pressure
- ☐ Currently Pregnant
- ☐ Arthritis (eg. Rheumatoid)
- ☐ HIV / AIDS
- ☐ Chronic Fatigue / Fibromyalgia
- ☐ Repeated Infections
- ☐ Thyroid Problems
- ☐ Skin Disease or Sensitivity
- ☐ Depression
- ☐ Asthma
- ☐ Epilepsy / Seizures
- ☐ Anxiety
- ☐ Viral Hepatitis
- ☐ Liver Disease (Fatty Liver)
- ☐ Fatigue
- ☐ Parkinson's Disease
- ☐ ADHD
- ☐ Allergies
- ☐ Digestive Problems
- ☐ Other _____
  _____
  _____

3. Please provide a list of any surgeries (including internal pins/wires/artificial joints), past injuries or major dental work you've had:

4. Please provide a list of your current medications:

5. I struggle with quitting smoking

1	2	3	4
Disagree	Somewhat Agree	Agree	Strongly Agree

6. I have difficulty sleeping through the night

1	2	3	4
Disagree	Somewhat Agree	Agree	Strongly Agree

7. I have significant stress in my life

1	2	3	4
Disagree	Somewhat Agree	Agree	Strongly Agree

8. I struggle with managing my weight

1	2	3	4
Disagree	Somewhat Agree	Agree	Strongly Agree

9. I am optimistic that my present problems will improve

1	2	3	4
Disagree	Somewhat Agree	Agree	Strongly Agree

Consent

Protecting your privacy and personal information is an important part of pt Health's policies and procedures. We strive to provide quality care and we collect, use, disclose, retain and dispose of your personal information in compliance with federal and provincial privacy legislation and applicable college regulations. We will try to be as open and transparent as possible about the way we handle your personal information.

pt Health is a multidisciplinary healthcare provider where the practitioners work together to provide you with complete healthcare. All staff members who come in contact with your personal information have signed a confidentiality form and are aware of the sensitive nature of the information that you have disclosed to us. They are trained in the appropriate use and protection of your information. As a patient, you are invited to read pt Health's privacy policy on our website at www.pthealth.ca. If you have any questions or complaints regarding pt Health's management of your personal information, we request that you contact the pt Health Privacy Officer at 1-866-749-7461 or via email at privacyofficer@pthealth.ca.

Our privacy policy outlines what our clinic is doing to ensure that:
- Only necessary information is collected about you
- We only share your information with your consent
- Storage, retention and destruction of your personal information comply with existing provincial and federal legislation, college regulations and privacy protection protocols.

How Our Clinic Uses and Discloses Patients' Personal Information
- To assess your health concerns, advise you of options and provide healthcare
- To establish and maintain contact with you
- To communicate with other treating healthcare providers, including your family doctor or referring physician
- To allow us to efficiently follow-up for treatment, care and billing via phone, email, addressed mail and voicemail
- To collect unpaid accounts and process credit card payments
- To comply with the law
- To complete claims for insurance purposes
- To invoice for goods and services
- To allow potential purchasers, practice brokers or advisors to conduct an audit in preparation for practice sale
- To contact you from time to time during treatment and post-treatment about new services, changes to services, special offers, surveys, clinic updates and other opportunities, by phone, email or addressed mail and voicemail

Medical
I give permission for my physicians, doctors and therapists, insurance company, WSIB, employer, lawyer, or rehabilitation counselor to discuss any medical information pertinent to this claim or injury. This permission is in effect for up to six months after I finish receiving care at pt Health.

Payment of Accounts
Accounts are interest-free for the first 30 days. Amounts over 30 days will be charged a monthly interest rate of 2.9%. Payments will be applied to interest first, then any past due amount.

Cancellation of Appointment
We appreciate 24 hours notice for any cancellations.

By signing the consent section of this patient consent form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information as outlined above. I have reviewed the above information and understand how pt Health will use my personal information and the steps pt Health is taking to protect my information. I agree that pt Health can collect, use and disclose personal information as set out above.

Name of Patient _____ Date _____
mm/dd/yy

Date of Birth _____
mm/dd/yy

Signature of Patient or Guardian ✔ _____

Thank you for completing this questionnaire. Your information is kept private and confidential.

Informed Consent

Treatment

I hereby give my consent to undergo therapy treatment. I have had the chance to discuss with my physicians, doctors and therapists the risks and benefits of treatment for my particular condition. Where appropriate, my treatment may include manual therapy, modalities (e.g. heat, ice, whirlpool, contrast bath, wax, laser, ultrasound, interferential current (IFC), electrical muscle stimulation, TENS, mechanical traction, acupuncture, dry needling, intramuscular stimulation), and active exercise. I understand that results are not guaranteed and that I may withdraw this consent at any time. If deemed appropriate by my therapist, I agree to have a student or support personnel carry out my treatment plan under supervision.

Name of Patient _____ Date _____
mm/dd/yy

Date of Birth _____
mm/dd/yy

Signature of Patient or Guardian ✔ _____

Additional Insurance Information

pt Health
SOLUTIONS TO GET WELL & STAY WELL

Coverage

☐ No Coverage ☐ Benefits ☐ Motor Vehicle Accident (MVA) ☐ OHIP ☐ Workplace Injury (WSIB)

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mm/dd/yy