ACCEL Physiotherapy & Sport Performance Centre
Intake Form

CONTACT

Name: _____

Mailing Address: _____ City: _____ Province: _____ Postal Code: _____

Phone Number: (home) _____ (work) _____ (cell) _____

Email Address: _____

Provincial Health Care Number (MSI): _____ Birth Date: _____ Age: _____

Emergency Contact Name: _____ Emergency Contact Phone #: _____

Occupation: _____ How did you hear about the ACCEL Centre: _____

HEALTH HISTORY

What is your main reason for seeking treatment today? _____

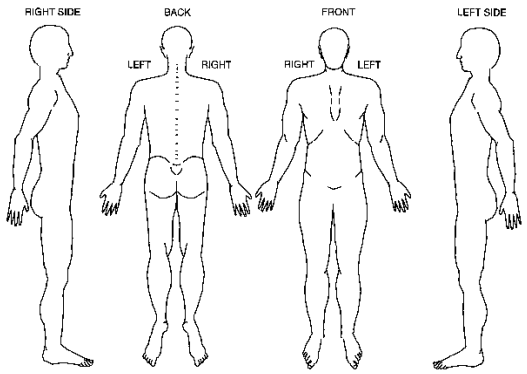
Are you presently involved in any other type of health care? ☐ No ☐ Yes Please describe: _____

Please list all current medications and supplements/ vitamins: _____

_____

Previous accidents and/or surgeries: _____

Please circle any area of pain or concern:



Please check any that apply:

- ☐ high/ low blood pressure
- ☐ heart disease/ attack
- ☐ heart murmur/ palpitations
- ☐ stroke/CVA
- ☐ pacemaker
- ☐ swelling/ edema
- ☐ phlebitis/ varicose veins
- ☐ blood clots/ embolism
- ☐ chest pain

- ☐ diabetes
- ☐ osteoporosis
- ☐ fibromyalgia
- ☐ epilepsy
- ☐ cancer
  what type: _____
- ☐ hepatitis
  what type: _____
- ☐ HIV/ AIDS
- ☐ herpes/warts
- ☐ athlete's foot

- ☐ skin condition/ allergies
  what type: _____
- ☐ bowel/ bladder issues
- ☐ gastrointestinal issues
- ☐ tingling/numbness
- ☐ paralysis
- ☐ respiratory issues
  what type: _____
- ☐ headaches/ migraines
- ☐ pregnancy due date: _____

- ☐ food or drug allergies
  list: _____
- ☐ presence of internal pins, wires, plates
- ☐ artificial joints/ limbs

Please list another issues your therapist should be aware of:

_____

_____

_____

An accurate medical health history is important to ensure it is safe for you to receive therapy. If you have a status change, please inform your therapist. All information is confidential, except for legal purposes or to facilitate diagnosis or treatment. I have answered all questions honestly and will update my therapist of any changes in my health in the future.

Signature of client and/or parent/guardian: _____ **Date:** _____

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CONSENT FOR RELEASE OF INFORMATION:
I authorize ACCEL Physiotherapy and Sport Performance Centre to use my email address, telephone numbers and mailing address, for appointment reminders and for treatment follow up.

I authorize ACCEL Physiotherapy and Sport Performance Centre to use and disclose my medical information for the purposes of treatment, payment and health care operations to the following: **(Please complete/check if applicable)**

Family Physician: _____

Personal Healthcare Insurer: _____ Other Name: _____

Motor Vehicle Accident (MVA)? ☐ No ☐ Yes Worker's Compensation Board (WCB) Claim: ☐ No ☐ Yes

MVA Insurance Provider: _____ WCB Claim Number: _____

I understand I have the right to revoke this consent provided that I do so **in writing,** except to the extent that ACCEL Physiotherapy and Sport Performance Centre has already disclosed the information based on this consent.

Signature of client and/or parent/guardian: _____ **Date:** _____

PAYMENT AGREEMENT:
Unfortunately, MSI does not cover any of our services; you, the client, are therefore responsible for payment of services rendered. **Payment is due at the time of your appointment.** Most clients are covered by some form of personal insurance. We direct bill Medavie Blue Cross, Great West Life, Manulife and Greenshield, Motor Vehicle Insurers and WCB**.** It is your responsibility to know the particulars of your plan; i.e. the percentage (%) of cost covered per treatment, the maximum allowable per year, when your policy expires and is renewed. Please notify us of any changes. If you are covered under more than one insurance policy, please note that we bill the primary policy only. Any amount not covered by this plan is your responsibility. (We reserve the right to refuse direct billing to any insurance company.)

PLEASE NOTE: If your claim is refused or denied by your personal health insurance, motor vehicle insurance or Worker's Compensation Board, you are responsible for all fees incurred during your treatment. These fees may include but are not limited to treatment fees, form fees, and/or product fees, etc.

CANCELLATION POLICY
If you are unable to attend your appointment, you are responsible for cancelling that appointment. **Please be advised we have a 24 hour cancellation policy.** (If calling after hours, weekends or holidays, please leave a detailed voice message.) Appointments that are cancelled with insufficient notice may be charged a cancellation fee. Cancelled or No Show appointments are subject to a $25.00 fee. Ask about our email confirmation system to assist with appointment reminders.

LATE ARRIVAL POLICY
Please note that if you are more than 15 minutes late for your scheduled appointment, you may be asked to reschedule.

I have read the terms of payment and agree to pay any and all fees associated with my (or my child/ward's) treatment and/or that has been refused or denied by my personal health insurance, motor vehicle insurance and/or Worker's Compensation Board. Further, I have read, understand and agree to the cancellation policy.

Signature of client and/or parent/guardian: _____ **Date:** _____

Witness: _____ **Date:** _____