KINSMEN SPORTS CENTRE
PHYSICAL THERAPY CLINIC

INTAKE FORM

NAME:_____ **PRONOUNS:**_____

(Last) (First) (Initial) (He / She / They / Them / Other)

Alberta Personal Health Number: __ __ __ __ __ / __ __ __ __

Date of Birth: _____ **Age:** _____

(Month / Day / Year)

Address: _____

_____

(City) **(Province)** **(Postal Code)**

Preferred Phone: _____ **Home□ Cell□ Work□**

Alternate Phone: _____ **Home□ Cell□ Work□**

Email Address: _____

Emergency Contact Person: _____

(Name) **(Phone)** **(Relationship)**

I would like electronic reminders of my appointments Yes □ No □ Email □ Text □

I am interested in receiving a clinic newsletter (quarterly) Yes □ No □

I consent to electronic communication regarding my appointments and treatment plan. Yes □ No □

How Did You Hear About Us?

Social Media □ **Dr Referral □** **Website □** **Friend Referral □** **Family Referral □**

Promo/Ad □ **Location □** **Prior Client □** **Google Search □**

CURRENT / PREVIOUS MEDICAL HISTORY

Family Physician or Referring Physician: _____

Have you had physical therapy for this body part? Yes □ No □ If yes: Clinic: _____ **Date:** _____

Did you have surgery for this injury or fracture a bone? Yes □ No □ If yes:

When: _____ **If a fracture, when was the cast removed?** _____

Do you have any of the following?

Cancer □	**Heart Disease □**	**COVID-19 □**	**Stroke □**	**HIV □**
Chronic Pain □	**Concussion □**	**Diabetes □**	**Migraine □**	**Fractures □**
Multiple Sclerosis □	**Pacemaker □**	**Osteoporosis □**	**Hepatitis □**	

Mental Health Concerns □

Rheumatic Conditions (RA, Polymyalgia Rheumatica, Ankylosing Spondylitis) □_____

Are you pregnant: Yes □ No □ How many months? _____

Are you taking any medications? _____

_____

Do you have any metal in your bones and / or joints? Yes □ No □ If yes where: _____

Surgical History: _____

Have you had any Diagnostic Tests / Imaging done for this condition (X-ray, ultrasound, MRI, etc.)Yes □ No □

If Yes: _____

Type of Test	**Body Part**	**Name of Imaging Location (MIC, Insight, etc.)**

<u>COVERAGE TYPE</u>

Is your injury related to work (WCB) Yes □ No □ If yes:

Claim Number: _____Date of Injury: _____Employer: _____

Is your injury related to a car collision / accident (MVC/MVA): Yes □ No □ If yes:

Claim Number:_____Date of Incident: _____Insurance Co. Adjuster:_____

Do you have Extended Health Care Benefits (Blue Cross, Sun Life, etc.)? Yes □ No □ If Yes:

Insurance Company: _____Policy / Group #: _____ID#: _____

Are you the Policy Holder? Yes □ No □ If no:

Policy Holder's Name: _____Date of Birth: _____Relationship: _____

I authorize payment for physiotherapy services to be made to the Kinsmen Sports Centre Physical Therapy Clinic. I understand I am responsible for any amount not covered by my benefit plan.

_____ <u>(Initials)</u>

PRIVACY POLICY

We are committed to protecting the privacy of your personal information. We will not disclose your personal information without consent or reasonable and lawful notice except when required or permitted by law. Our complete privacy policy is available upon request. All staff members have signed a confidentiality agreement and have been trained in the appropriate uses and protection of your information. We collect contact, health, and financial information. We use this information to:

- **Communicate with you to schedule / cancel future appointments via email/telephone/text or by other means**
- **Communicate with you and other health care providers involved in your care**
- **Exchange personal information concerning any claims submitted with the plan member or a plan member acting on their behalf**
- **Collect payments, process billing and all financial matters relating to your account**
- **To complete claims forms for insurance purposes including extended health plans, automobile insurance, WCB etc.**
- **Audit day to day internal business functions**
- **_____ (Initials)**

CANCELLATION POLICY

Attending your appointments and avoiding last minute cancellations or no-shows is essential to an effective treatment program. Please accept only those appointments that you will be able to keep. When you schedule an appointment that time is reserved for you. Late cancellations and missed appointments affect the physiotherapist and other clients of the Clinic.

As a courtesy to our staff and other clients, please provide 24 hours notice should you need to cancel an appointment. This affords our staff the time to schedule another client who requires treatment. If you cancel after 7:00 AM on the day of your appointment or fail to attend an appointment without notification, you will be charged a missed appointment fee of $40.

Extenuating circumstances, such as illness, emergency or accident, will be considered on a case-by-case basis.

Please be aware that insurance companies, the WCB, and Alberta Health Services WILL NOT pay for missed appointments on your behalf.

_____ (Initials)

INFORMED CONSENT

I consent to undergo assessment and treatment. I understand I provide consent to assessment and the fees associated with that assessment. I have been informed of the various treatment options available to me as well as the risk/benefits associated with a given care plan. I understand treatments may include, but are not limited to education, exercise, manual therapy (including manipulation), dry needling (acupuncture, IMS), electrical modalities (ultrasound, muscle stimulation, interferential current). I understand I may withdraw my consent at any time and that consent is an ongoing process between me and my physiotherapist. Results of a given care plan are not guaranteed. Feedback is an important part of physiotherapy. I acknowledge it is my responsibility to inform my physiotherapist of any adverse events (pain, discomfort, side effects, etc.) related to my treatment.

CONDITIONS OF SERVICE

Clients are required to pay privately, as per the posted fee schedule.

My signature below acknowledges my understanding of my liability for any costs incurred by me at this office. Payment options include Debit, Visa, Mastercard, electronic transfer, cash, or cheque.

Our staff will make every effort to inform you of outstanding balances in a timely fashion. Payments and fees not covered by any health care / insurance policy are the sole responsibility of the client. Outstanding balances over 30 days are charged a monthly interest fee.

My signature below also permits disclosure of information relating to my attendances to my Extended Health Benefit Provider, the Workers' Compensation Board, and / or my automobile insurance company for the purposes of confirming my attendance and the nature of my submitted claim.

I understand my personal information is being collected under the authority of the Health Information Act (HIA), the Personal Information Protection Act (PIPA), and the Personal Information Protection and Electronic Documents Act (PIPEDA).

I also understand the information collected about me during the assessment may be disclosed to my physician as part of the circle of medical care.

If you have any questions throughout the course of your physiotherapy sessions, please do not hesitate to discuss them with your physiotherapist or Clinic personnel.

Signature: _____ Date: _____

Parent / Guardian Signature if patient under the age of 18