BURLINGTON PHYSIOTHREAPY & HEALTH CLINIC

2004 Caroline Street ● Burlington, ON ● L7R1K9 ● Tel: (905) 333-1515

Patient Intake

PERSONAL INFORMATION

TITLE: MR. ☐ MRS. ☐ MISS. ☐ MS. ☐ DR. ☐				DATE
FIRST NAME	INITIAL	LAST NAME		OCCUPATION
ADDRESS		CITY	PROVINCE	POSTAL CODE
HOME TELEPHONE	CELLULAR PHONE	BUSINESS PHONE	EMAIL ADDRESS	
BIRTH DATE DAY/MONTH/YEAR	SEX ☐ MALE ☐ FEMALE	HOW DID YOU HEAR ABOUT US?		
IN CASE OF EMERGENCY				
CONTACT NAME		TELEPHONE		RELATIONSHIP

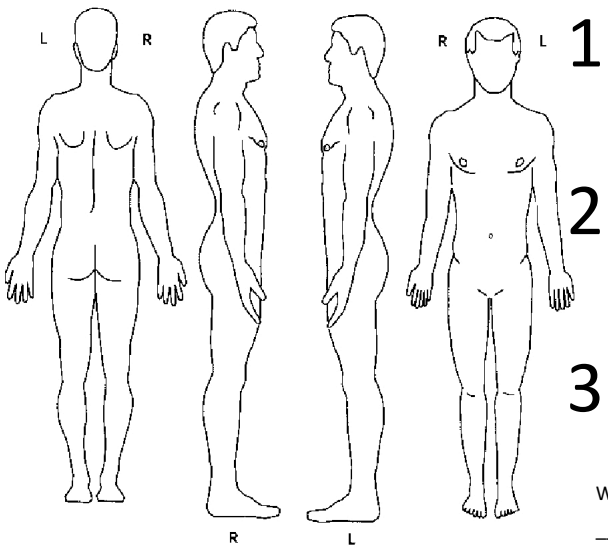
MEDICAL INFORMATION

DO YOU HAVE A MEDICAL DOCTOR? ☐ Yes ☐ No *IF YES, PLEAE COMPLETE THE FOLLOWING.*

DOCTOR'S NAME	DOCTOR'S TELEPHONE NUMBER		LAST VISIT
ADDRESS	CITY	PROVINCE	POSTAL CODE
DO YOU HAVE ANY ALLERGIES	ARE YOU MAKING A CLAIM FOR	1) RECENT MOTOR VEHICLE ACCIDENT ☐ YES ☐ NO 2) WORK RELATED INJURY/ACCIDENT (WSIB) ☐ YES ☐ NO	

CHIEF COMPLAINT

Foot



HOW TO COMPLETE THIS DIAGRAM

On the body to the left, using the symbols below, please mark the location of your primary complaint and described sensation.

Ache	Burning	Numbness	Tingling	Stabbing/Sharp	Deep
XXXX	++++++	^^^^^	******	/////////	======

How did your symptoms start?

- □ sudden
- □ gradual
- □ car accident
- □ work related injury

When did your symptoms start?

- □ 0-3 months ago
- □ 3-6 months ago
- □ 6-9 months ago
- □ 1 year or more ago

Please mark on the line below the level of your discomfort.

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0 no pain — 10 worst pain

What is the reason for seeking care today? _____

_____

Have you sought treatment from any other health care professional? □ YES □ NO

Treatment Received _____

_____

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• 2004 CAROLINE STREET • BURLINGTON, ON • L7R 1K9 • TEL: (905) 333-1515

Patient Informed Consent of Policies

Benefit Assignment: You assign all medical benefits to Burlington Physiotherapy & Health Clinic Ltd. (BPHC). Including extended health insurance, auto insurance, worker's compensation or other insurance plans. You agree that if insurance pays directly to you, this monetary amount is actually due to BPHC and is the patient responsibility.

Billing Information: Outstanding patient responsibility balances as determined by your insurance carrier are your responsibility and are due. You are ultimately responsible for any allowed charges not covered by your insurance company(s). It is your responsibility to provide BPHC with correct information including insurance, pre-certifications, responsible party, date of injury, type of accident, policy and/or group numbers, etc. Should the information change, it is your responsibility to update it within a timely manner. If you supply BPHC with incorrect information, the balance of the account at the last date of service will be entirely the patient's responsibility. BPHC will not be responsible for rebilling, appealing or other dealings with newly provided insurance companies.

Past Due Accounts: If your account becomes past due, we may need to take necessary steps to collect this debt. This may include contacting the person listed as Spouse or Emergency Contact on your patient data sheet. If we have to refer your account for collection, you agree to pay all of the collection costs which are incurred.

Missed Appointment Fee: **The full cost of the missed appointment will be charged for any missed appointments or appointments cancelled with less than 24 hour notice.** It is under BPHC discretion to charge directly to the form of payment provided below upon missed appointments. We understand that emergencies do occur and will attempt to make reasonable accommodations for that. There is a one-time leniency for missed appointments. Upon repeated missed appointments this fee will be charged. This fee is not billable or payable by insurance. Patients with more than two missed appointments in succession will be discharged from therapy and referred back to their Primary Care Provider.

Name As It Appears On Credit Card _____

Credit Card Number _____Date of Expiry_____/_____

Waiver of Confidentiality: You understand if this account is submitted to an attorney or collection agency or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

I have been informed of my financial responsibility and agree to the terms and conditions as stated on this form. I understand that my health insurance policy is a contractual agreement between my insurance carrier and me. It is therefore MY RESPONSIBILITY to question my insurance company regarding delays in payment and/or denial of coverage, incorrect processing of claims by the insurance company, as well as any requirements that may be included in my insurance policy coverage (ie. pre-certifications, in-network status, referrals, co-insurances, and deductibles).

_____	_____	_____
Name of Client	Signature of Client	Date

INSURANCE PROVIDER	MEMBER NAME	PLAN/GROUP #	MEMBER ID #	