



WELCOME NEW PATIENT

First & Last Name

Address

City

Postal Code

Telephone (B)

(H)

Fax

Email

Date of Birth

Day

Month

Year

Doctor

Telephone

How did you hear about Personal Best?

Family Physician

Specialist

Friend

Advertisement

Other

RELEASE OF INFORMATION

By signing this form, I authorize Personal Best Physiotherapy to obtain/ release medical information pertaining to myself

Please write the name of your doctor, WCB, Insurance Co., Rehabilitation Co. above

I understand that 24 hour notice for any change or cancellation to my appointment is required or charges will apply for the appointment.

Patient Signature

Date

This Clinic is not covered by WCB or OHIP

MOTOR VEHICLE ACCIDENT

If you have been involved in a motor vehicle accident, please fill in this section

Name of Insurance Company

Address of Insurance Company

Claim number

Insurance Agent's Name

Insurance Agent's Telephone

HEALTH CONSENT FORM

We want your informed consent. This means that we want you to understand the services we provide and how we use your personal information.

ASSESSMENT AND TREATMENT

I consent to assessment by a member of the clinical staff at *Personal Best Physiotherapy*. I am responsible for deciding whether to follow the recommendations made by a clinician. I understand that I may not respond to treatment recommended. I understand that I may ask questions related to my conditions, assessment results and treatment recommendations.

COLLECTION AND USE OF PERSONAL INFORMATION

I understand to complete my assessment and provide services, staff will collect some personal information about me. I agree to *Personal Best Physiotherapy* collecting, using and disclosing personal information about me as required to my physician, allied health care providers involved in my care, insurance provider or third parties payers if applicable.

INFORMATION ON THE COST OF OUR SERVICES

WSIB/OHIP does not cover any of our services. In some cases extended health insurance will cover the costs. It is the patient's responsibility to verify their insurance coverage.

CLINIC FEES

Physiotherapy/Pilates Rehabilitation with a Registered Physiotherapist

- Assessment 60 minutes \$125.
- Follow Up 45 minutes \$90.
- Follow Up 30 minutes \$70.

Physiotec program/exercise addition \$5. per session added to the above fees.
HST is not applicable to physiotherapy services.

Private Pilates Sessions with a Certified Pilates Instructor

- 60 minutes \$85 + HST = \$96.05

Post Rehab Exercise Session with Registered Kinesiologist

- 60 minutes \$80 + HST = \$90.40

Forms, Letters, Telephone consultations

- Basic \$25. + HST

The patient is responsible for full payment to *Personal Best Physiotherapy* for goods and services provided at the end of each appointment.

Today's Date

Patient Signature

Patient Name *print clearly*

If the patient has a legal guardian, please provide

Legal Guardian Signature

Legal Guardian Name *print clearly*

PHYSIOTHERAPY AND YOU

Please briefly write in your own words the primary reason for your Physiotherapy consult *e.g. back & leg pain*

Have you been to physiotherapy in the past? Yes No

If yes, briefly explain for what condition and type of therapy *e.g. manual therapy, machines, exercises*

Are you currently taking any medication? Yes No

Please list

Have you had any surgeries in the past? Yes No

Please list

Do you currently have or have a history of any medical condition(s)? Please check all that apply

- | | | |
|---|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Recent infection <i>eg. chest, urinary tract</i> | <input type="checkbox"/> Wrist/hand pain |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Broken bones/fractures | <input type="checkbox"/> Knee pain |
| <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Skin diseases | <input type="checkbox"/> Neck pain |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Jaw pain |
| <input type="checkbox"/> Respiratory / lung problems | <input type="checkbox"/> Cancer | <input type="checkbox"/> Shoulder pain |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Hip pain |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Incontinence / lack of bladder control | <input type="checkbox"/> Low back pain |
| <input type="checkbox"/> Insomnia/difficulty sleeping | <input type="checkbox"/> Pace maker | <input type="checkbox"/> Ankle/foot pain |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Mid back pain |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Heart attack | |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Thyroid problems | |

Allergies:

Other

Do you currently or have a history of being a smoker? Yes No

Have you had any of the following medical images? Yes No

Please list including for what condition

- X-ray Diagnostic ultrasound CT scan MRI Other

