PATIENT INTAKE FORM

Name: ________________________________ M ☐ / F ☐ Date of Birth: _m__/_d__/__y__

Address: ____________________________ Apt.____ City: ______________ Postal Code: ____-____

Home: (____)______- _______ Work: (____) ______- _______ Cell: (____) ______- _______

Email Address: ___________________________ Do you want to be updated via Email? Yes ☐ No ☐

Occupation: ____________________________ Employer ___________________________

How did you hear about us? ____

Family Physician: Dr. ___________________________ Permission to Consult? Yes ☐ No ☐ Initial: ____

Physicians Phone No. (____) _____-_______ Fax No. (____) ______-__________________

Main Interest For Today's Visit? ☐ Chiropractic ☐ Physiotherapy ☐ Massage ☐ Orthotics ☐ Other ____________

Are you receiving treatment by any other health professional? ☐ No ☐ Yes ___________________________

Therapy Goals: ☐ Pain Relief ☐ Flexibility ☐ Core Strength/Endurance ☐ Improved Posture ☐ Weight Loss ☐ Maintenance

1) Primary Insurance Company: _____________ Group/Policy:_________________ ID: _______________

Policy Holder? ☐ Self ☐ Spouse ☐ Parent Name: _______________________ DOB: _m__/_d__/__y__

2) Secondary Insurance Company ____________ Group/Policy:__________________ ID: _____________

Policy Holder? ☐ Self ☐ Spouse ☐ Parent Name: _________________________ DOB: _m__/_d__/__y__

Auto Accident Information

Insurance Company: ____________________________

Claim No. ____________ Accident Date _m__/_d__/__y__

Adjustor Name: ______________ (P) ______________

(F) ______________

WSIB Information

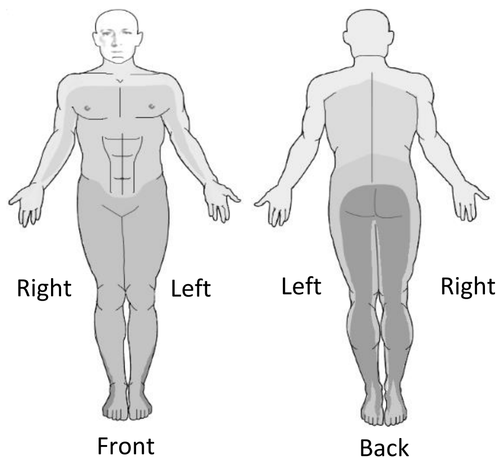
Is This a New Injury Claim? Yes ☐ No ☐

Claim No. ____________ Accident Date _m__/_d__/__y__

Adjudicator Name: ______________ (P) ______________

(F) ______________

In the diagram and using the symbols below mark the areas on your body that you feel best represents the location and type of pain or sensation you are **currently** experiencing.



0 ________________________________ 10

Place a vertical mark along the line to indicate your level of pain (0 being the least pain and 10 being the worst pain)

Tight/Stiff	(**X**)	Sharp	(**/**)
Burning	(**O**)	Numbess	(●)

Use the symbols above to indicate the type of pain or sensation you are currently experiencing

Please check the following health conditions/procedures that apply to **you**, both past (X) and present (✓)

☐ Abdominal Pain	☐ Headache/Migraine	☐ Muscle Cramps/Spasm	☐ Scoliosis
☐ Arthritis	☐ Heart Disease/Attack	☐ Neck Pain/Stiffness	☐ Sciatica
☐ Chronic Pain	☐ Hyper/Hypo-Tension	☐ Numbness/Tingling	☐ Spinal Cord Injury
☐ Diabetes	☐ Joint Pain/Stiffness	☐ Osteoporosis	☐ Sprain / Strain
☐ Fatigue/Weakness	☐ Kidney Problems	☐ Poor Circulation/Bruising	☐ Stroke/Aneurysm
☐ Fracture	☐ Low Back Pain	☐ Rheumatoid Arthritis	☐ Thyroid Disease
☐ Sensitivities/Allergies	☐ Loss of Sensation	☐ Cancer	☐ Pacemaker
☐ Ear Problems	☐ Vison Loss/ Problems	☐ Varicose Veins/Phlebitis	☐ Other __________

Infections: ☐ Hepatitis ☐ Skin Condition ☐ TB ☐ HIV ☐ Herpes ☐ Other Gynecological Infections ________

Respiratory: ☐ Chronic Cough ☐ Shortness of Breath ☐ Bronchitis ☐ Asthma ☐ Emphysema

Are you pregnant? ☐ No ☐ Yes How far along? ________ How is your general health? ________________

Do you take any medications? No ☐ Yes ☐ ____

Surgery History? ____

Please check the health conditions that you apply to your **immediate family**, both past (X) and present (✓)

☐ Cancer _______________	☐ Diabetes ________________	☐ Stroke/Aneurysm ______________
☐ Heart Disease __________	☐ Cholesterol ______________	☐ High Blood Press. ______________
☐ Respiratory Problems _____	☐ Arthritis _______________	☐ Other ______________________

<u>Payment Options and Acknowledgment</u>

Please Note: Payment method selected will be dependent on your insurance. Claims submitted by the clinic (SRA/AOB/MVA/WSIB) will require a credit card to be kept on file.

☐ <u>Pay As You Go:</u> The patient will pay for services rendered and/or product received by CORE HEALTH CARE on a pay per visit basis. Payment is required following each service. Invoices will be provided to the patient who will be responsible for submitting claims to their extended health care provider for reimbursement, unless otherwise specified.

☐ <u>Service Rendered Agreement (SRA):</u> Invoices will be processed by CORE HEALTH CARE and sent to the patient's extended health care provider via mail or online (i.e) Telus Health E-Services. The patient will be charged any outstanding balances on their account for services rendered and/or product received and reimbursed directly by their insurance company.

☐ <u>Assignment of Benefits (AOB):</u> Invoices will be processed by CORE HEALTH CARE and sent to the patient's extended health care provider via mail or online (i.e) Telus Health E-Services. The patient will sign all necessary insurance forms allowing the "authorization of payment" from the insurance company directly to CORE HEALTH CARE for all services rendered and/or product received.

☐ <u>Motor Vehicle Accident (MVA) / Workplace Safety and Insurance Board (WSIB):</u> The patient will sign all necessary insurance claim forms allowing the "authorization of payment" from the insurance company directly to CORE HEALTH CARE for all services rendered and/or product received. CORE HEALTH CARE will be responsible for submitting all claims to the patient's MVA Insurance Company or WSIB.

I have read and or have been explained the payment options available to me, including all terms and conditions set out by CORE HEALTH CARE and agree to abide by them all times of treatment. I understand that payment is expected in full for all services rendered and/or product ordered and that I may at any time request any paid or unpaid invoices to my account. While CORE HEALTH CARE may record insurance information the PATIENT is ultimately responsible for tracking their services, billings and coverage limitations. I have read agreed to the above mentioned payment option(s).

______________________________ ____________________

Patient Signature *Date (m/d/yy)*

<u>CREDIT CARD INFORMATION</u>

Claims submitted by the clinic on behalf of patients and/or insurance plans that incur a deductible or provide partial payment will require the patient's <u>credit card information</u> to be kept on file and subsequently billed for any outstanding balance that for any reason is not covered by their insurance policy or by the patient themselves. Credit card information will be kept strictly confidential and will only be charged for outstanding amounts owed for services or products that have been rendered or provided.

I have agreed to the above mentioned payment option(s) and thus allow CORE HEALTH CARE to debit my credit card for any outstanding balances as they are incurred on my account as set out in this policy.

______________________________ ______ ________ ____________________

Credit Card Number *Type* *3 digit CSC code* *Card Expiry Date (m/yy)*

______________________________ ____________________

Patient Signature *Date (m/d/yy)*

Clinic Policy

CORE HEALTH CARE maintains a standard clinic policy designed to maintain a fair and professional relationship toward all our patients in order to provide the most efficient and effective care possible. As a patient we require you to provide accurate and honest information as it relates to your personal and medical health history and that you be considerate to the doctors, therapists, administration staff and fellow patients while attending our facility. *Initial:* _____

Information/Record Keeping Policy

CORE HEALTH CARE requires a certain amount of information as it relates to your current condition and relevant health history in order to provide you with the most appropriate and efficient care possible. CORE HEALTH CARE is responsible for the privacy of all our patients and all information provided will be kept strictly confidential. *Initial:* _____

Cancellation Policy

CORE HEALTH CARE enforces a strict cancellation policy to ensure that any given patient can receive the care they need on any given day. Therefore CORE HEALTH CARE requires a 24 hours notice for cancellation of any appointment. A fee of **$50** will be charge for missed appointments without a 24 hour notification. This fee is not covered by insurance plans and thus must be paid at the client's own expense.

Initial: _____

Financial Policy

All services rendered are to be paid for at the time of service. All services provided are covered by most Extended Health Care plans and all patients will be provided with the appropriate invoices for submission to their respective insurance company, unless otherwise specified. *Initial:* _____

Policy Agreement and Informed Consent

I have read, understand and agree to the clinic policy's set forth by CORE HEALTH CARE. To the best of my knowledge, I certify that the information provided in the above forms is accurate and that I will advise CORE HEALTH CARE Staff of any changes pertaining my personal information and relevant health history.

______________________________ ______________________________ ____________________

Patient Signature or Parent/Legal Guardian   Patient Name or Parent/Legal Guardian (Printed)   Date (m/d/y)