154 West Main St.
Welland, ON L3C 5A2
Phone: 905.732.1278 Fax: 905.732.3451

2-5547 Portage Road
Niagara Falls, ON L2G 5Y2
Phone: 905.358.9090 Fax: 905.358.6363

PAYMENT INFORMATION

I understand that it is my responsibility for the payment of services rendered at Generations Sport & Spine Physiotherapy Centre. If my claim is to be submitted directly to an outside agency for payment and for some reason the third party payer, such as but not limited to WCB/WSIB, insurance or employer, denies the claim and or/refuses to pay all or any of the full amount billed, I am responsible for paying the amount outstanding. To improve the efficiency of payment, I will make the payment up front and I will be responsible for claim submission to my insurance holder for re-imbursement of fees. I understand that the fees per visit for this service are:

Initial Assessment - $80.00 Treatment - $60.00 _____Initials

INFORMED CONSENT FOR PHYSIOTHERAPY TREATMENT

By signing this form, I voluntarily consent to receive physiotherapy services and am aware that I require treatment by a physiotherapist. I have discussed with the physiotherapist the risks and benefits of treatment for my particular condition. My treatment may include manual therapy including manipulation, modalities (e.g., heat, ice, contrast bath, wax, laser, ultrasound, shockwave, interferential current, electrical muscle stimulation, TENS, mechanical traction, acupuncture), and active exercise. I understand that I may withdraw my consent at any time, and that results are not guaranteed. At times, portions of my treatment may be carried out by a physiotherapist support personnel, kinesiologist, or physiotherapist student, as this clinic is a teaching clinic in addition to a treatment facility. If I have any questions or concerns about any recommended treatment I must inform the therapist immediately so they can explain the treatment rationale and/or modify my program accordingly. I understand that I have the right to ask my physiotherapist to explain any procedure and treatment prescribed so that I fully understand the treatment recommended.

I give permission for my physician, physiotherapist, treating therapist, insurance company, WSIB, employer, lawyer, or rehabilitation counselor to discuss any medical information pertinent to this claim. This permission is in effect for up to 1 year following the completion of treatment at Generations Sport & Spine Physiotherapy Centre.

INFORMED CONSENT TO RECEIVE EMAILS

Upon providing my email address, I give permission and understand that Generations Sport and Spine Physiotherapy will send emails to confirm upcoming appointments. Generations Sport and Spine Physiotherapy will not use my email address for any marketing materials and will not provide my email address to anyone outside of their company.

Name: _____ Signature: _____Date: _____

Witness: _____ Date: _____

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New Patient Registration Form

Patient Information:

Today's Date: _____

First Name:_____ Last Name: _____

Address:_____City: _____

Postal Code: _____

Birth Date (d/m/y):_____ Sex: Male □ Female □

Phone Number:_____Cell Number: _____

Email: _____

Family Doctor:_____Specialist: _____

Referring Doctor: _____

If Patient is a Minor:

Mother's Name:_____ Phone Number: _____

Father's Name:_____ Phone Number: _____

Emergency Contact:

First Name:_____Last Name: _____

Phone Number:_____ Relationship: _____

Referred to Clinic by: Doctor □ Family □ Friend □ Advertisement □ Other □

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Patient Health Questionnaire

Patient Information:

Today's Date: _____

First Name:_____ Last Name: _____

Complaint/Condition:

Please describe your current complaint or condition:

_____
_____
_____
_____

Please describe how and when your problem began:

_____
_____
_____
_____

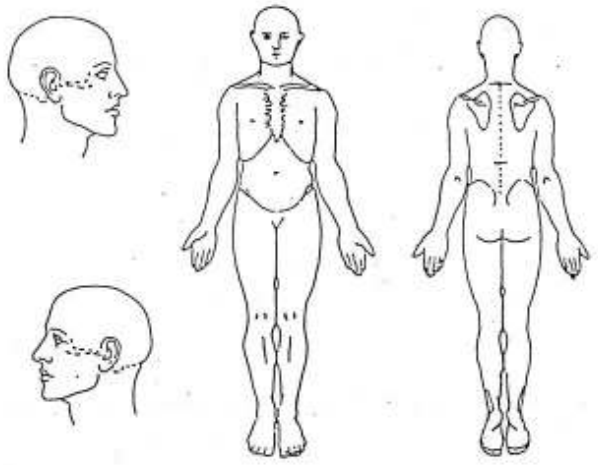
Date your problem began (if possible): _____

Did you have surgery for this condition? Yes □ No □ if yes, Date of Surgery: _____

Other tests X-Ray___MRI_____CT Scan____Bone Scan_____EMG _____

Others: _____

Please indicate (circle or an “x”) on the following diagram, your significant areas of pain/discomfort:



Please describe the nature of your pain:

□ Sharp Pain □ Dull (Ache) Pain □ Throbbing □ Burning □ Numbness □ Shooting
□ Constant (76-100%) □ Frequent (51-75%) □ Occasional (26-50%) □ Intermittent (<25%)

Indicate which of the following activities affect your symptoms:
___ Morning____Evening____Activity____Rest____Heat____Cold____Sitting____Standing
___ Walking____Twisting____Bending____Reaching____Lifting____Carrying____Push/Pull
___ Stairs____Coughing____Sneezing

Intensity of pain at best:

□ No pain □1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □9 □10

Intensity of pain at worst:

□ No pain □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

Have you had physical therapy treatment, for this condition, in the past?

Yes □ No □ if yes, Date:_____and Place _____

Was treatment effective: Yes □ No □

Have you received any treatments from other health professionals for your current or related problems?

_____

_____

Occupation: _____

Has your work status changed because of this condition? Yes □ No □

Health Information: If you have ever had a listed condition in the past, please check in the PAST column. If you presently have a particular condition, check in the PRESENT column. This information assists us in understanding your state of health.

Past:

□ High Blood Pressure
□ Angina
□ Heart Attack
□ Stroke
□ Asthma
□ Diabetes
□ Arthritis
□ Rheumatoid Arthritis
□ Headaches
□ Recent weight gain or loss
□ Musculoskeletal Disorder (e.g., osteoporosis, muscle pain, fractures)
□ Depression
□ Cancer (list location and date below)
□ Systemic Lupus
□ Hepatitis
□ Epilepsy
□ HIV/AIDS
□ Pregnancy
□ Drug or Alcohol Dependence
□ Tobacco packs/day (list below)
□ Other (list below)

Present:

□ High Blood Pressure
□ Angina
□ Heart Attack
□ Stroke
□ Asthma
□ Diabetes
□ Arthritis
□ Rheumatoid Arthritis
□ Headaches
□ Recent weight gain or loss
□ Musculoskeletal Disorder (e.g., osteoporosis, muscle pain, fractures)
□ Depression
□ Cancer (list location and date below)
□ Systemic Lupus
□ Hepatitis
□ Epilepsy
□ HIV/AIDS
□ Pregnancy
□ Drug or Alcohol Dependence
□ Tobacco packs/day (list below)
□ Other (list below)

Additional Information Here:

_____

_____

Hospitalization/Surgical Procedures: (list if not described elsewhere):_____

_____

_____

Medications:_____

_____

_____

Signature:_____ Date: _____

_____

Disclaimer: Any personal information you provide upon registration or by making/attending an appointment is held in strictest confidence, adhering to the Personal Health Information Protection Act to protect your privacy.

WSIB Claims ONLY:

Employer Name:_____Employer Contact Name: _____

Employer Address:_____Contact Number: _____

Contact Fax:_____Job Title/Occupation: _____

Length of time at current job:_____Claim Number: _____

Date of Injury/Accident: _____

Motor Vehicle Accident (MVA) Claims ONLY:

Auto Insurance Company Name: _____

Claim Number:_____Policy Number: _____

Adjuster Name:_____Adjuster Phone Number: _____

Date of Injury/Accident: _____

Are you the Vehicle Policy Holder? Yes □ No □

If No, Name of Vehicle Policy Holder: _____

Do you have Extended Health Care Benefits? Yes □ No □

If Yes, Name of Benefit Company: _____

Are you the Benefit Policy Holder? Yes □ No □

If No, Name of Benefit Policy Holder: _____

Group/Policy #:_____ ID#: _____

Policy renewal: on calendar year:_____ or Month: _____

Dr. Script Required _____

Amount of Coverage Per Year $_____; Payout 80% □ 100% □ Other □

Release of Information:
I give my permission to Generations Sport & Spine Physiotherapy Centre to release information to my insurance company, attorney and beneficiaries.

As Applicable ►Assignment of Benefits:

I authorize payment directly To Generations Sport & Spine Physiotherapy Centre for services rendered.

Signature:_____Date: _____