SHEDDON PHYSIOTHERAPY AND SPORTS CLINIC

1300 Cornwall Rd, Suite 103, Oakville, Ontario, L6J 7W5

Massage Therapy Health History Form

The information requested below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided below will be kept confidentially unless allowed or required by law. Your written permission will be required to release any information.

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss

Name _____ Phone # _____

Address _____ City: _____ Postal Code: _____

Email address: _____

Occupation _____ Date of Birth _____

How did you hear about us? _____

Have you received massage therapy before? ☐ Yes ☐ No

Did a health care practitioner refer you for massage therapy? ☐ Yes ☐ No

If yes, please providetheir name _____

Cardiovascular

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chronic congestive heart failure
- ☐ Heart attack
- ☐ Phlebitis / varicose veins
- ☐ Stroke / CVA
- ☐ Pacemaker or similar device
- ☐ Heart disease

Is there a family history of any of the above? ☐ Yes ☐ No

Respiratory

- ☐ Chronic cough
- ☐ Shortness of breath
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema

Is there a family history of any of the above? ☐ Yes ☐ No

Infections

- ☐ Hepatitis
- ☐ Skin conditions
- ☐ TB
- ☐ HIV
- ☐ Herpes

Other Conditions

- ☐ Loss of sensation, where? _____
- ☐ Diabetes, onset: _____
- ☐ Allegies / Type of reaction _____
- ☐ Epilepsy
- ☐ Cancer, where? _____
- ☐ Skin conditions, where? _____
- ☐ Arthritis

Is there a family history of arthritis? ☐ Yes ☐ No

Head/Neck

- ☐ History of headaches
- ☐ History of migraines
- ☐ Vision problems
- ☐ Vision loss
- ☐ Ear problems
- ☐ Hearing loss

Women

- ☐ Pregnant, due: _____
- ☐ Gynaecological conditions, what? _____

Overall, how is your health? _____

Primary Care Physician: _____

Address: _____

Current Medications: _____

Condition it treats: _____

Are you currently receiving treatment from another health care professional? ☐ Yes ☐ No

If yes, for what? _____

Surgery – date _____

nature: _____

Injury – date _____

nature: _____

Did you have any other medical conditions? (e.g. digestive conditions, haemophilia, osteoporosis, mental illness)

☐ Yes ☐ No what? _____

Do you have any internal pins, wires, artificial joints or special equipment? ☐ Yes ☐ No

What? _____

Where? _____

What is the reason you are seeking massage therapy?

Please indicate the location of any tissue or joint discomfort.

_____

_____

_____

1. I have stated all medical conditions and will update my therapist of any changes in my health status. I have the right to stop, change or request modification of my treatment within the scope of practice of the therapist. I consent to be treated by a Registered Massage Therapist**. I understand and agree to provide a minimum of 24 hours' notice to change/reschedule appointments or a no-show/cancellation fee may be charged and I understand this fee is not covered by extended health benefit plans.**

Signature: _____ Date: _____

SHEDDON PHYSIOTHERAPY AND SPORTS CLINIC

1300 Cornwall Rd, Suite 103, Oakville, Ontario, L6J 7W5
TEL: (905) 849- 4576 FAX: (905) 849-7856 www.sheddonphysio.com

Extended Health Benefits Electronic Transmission Authorization & Consent Form

Instructions: This form must be filled out when claims are submitted electronically by the provider on the patient's behalf. Please retain this form in the patient's file for verification purposes for two years following closure of the patient file.

Provider: Sheddon Physiotherapy and Sports Clinic
Address: 1300 Cornwall Rd, Suite 103
City/Province: Oakville/Ontario
Postal Code: L6J 7W5
Phone Number: 905-849-4576

Insurance Company Name: _____

Policy / Plan Number: _____

Certificate / ID #: _____

Policy Holder Name: _____ DOB (dd/month/YYYY): _____

Patient Name(s): _____

Address: _____

City/Province/Postal Code: _____

Phone Number: _____

Benefit Assignment Form (Payment Assigned to Clinic)

I hereby assign benefits payable for the eligible claims to the Provider responsible for submitting my claims electronically to the group benefits plan and I authorize the insurer/plan administrator to issue payment directly to the Provider. In the event my claim(s) are declined by the insurer/plan administrator, I understand that I remain responsible for payment to the Provider for any services rendered and/ or supplies provided.
I acknowledge and agree that the insurer/plan administrator is under no obligation to accept this Assignment, that any benefit payment made in accordance with this Assignment will discharge the insurer/plan administrator of its obligations with respect to that benefit payment, and that in the event the benefit payment is made to me, the insurer/plan administrator will also be discharged of its obligation with respect to that benefit payment.
I understand that this Assignment will apply to all eligible claims submitted electronically by the Provider and that I may revoke it at any time by providing written notice to the insurer/plan administrator.
If I am a spouse or dependent, I confirm that I am authorized by the plan member to execute an assignment of benefit payments to the Provider.

Print Name: _____

Signature: _____

Date: _____

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Consent to Collect and Exchange Personal Information

Message to the Plan member, Spouse and/or Dependent regarding Personal Information
Personal information that we collect and disclose about you, and if applicable, your spouse and/or dependents, is used by the insurer and/or plan administrator and their service provider(s) for the purposes of assessing your claims, underwriting, investigating, auditing and administering the group benefits plan, including the investigation of fraud and / or plan abuse.

Authorization and Consent

I authorize my healthcare provider to collect, use and disclose personal information concerning any claims submitted on my behalf with the insurer and/or plan administrator and their service provider(s) for the above purposes.
I authorize the insurer and / or plan administrator and their service provider(s) to:

- Use my personal information for the above purposes.
- Exchange personal information with any individual or organization, including healthcare professionals, investigative agencies, insurers and reinsurers, and administrators of government benefits or other benefits programs when relevant for the above purposes
- Exchange personal information concerning any claims submitted with the plan member or a person acting on behalf of the plan member.
- Exchange personal information of the above purposes electronically or in any other manner.

I understand that personal information may be subject to disclosure to those authorized under applicable law.

I understand that a photocopy or electronic version of this authorization shall be as valid as the original and may remain in effect for the continued administration of the group of benefits plan.

Additional Consent Applicable to Plan Members Only

I confirm that I am authorized by my spouse and/or dependents, if any, to disclose personal information about them to the insurer and/or plan administrator and their service provider(s) for the purposes described above and I confirm that my spouse and/or dependents also authorize the insurer and/or plan administrator and their service provider(s) to disclose information about their claims to me, for the purposes of assessing and paying a benefit, if any, and managing the group benefits plan. I also authorize my spouse and/or dependents to assign benefit payments under the plan to the healthcare provider.
In the event there is suspicion and/or evidence of fraud and/or plan abuse concerning claims submitted, I acknowledge and agree that the insurer and/or plan administrator and their service provider(s) may use and disclose relevant personal information to any relevant organization including law enforcement bodies, regulatory bodies, government organizations, medical suppliers and other insurers, and where applicable my Plan Sponsor, for the purposes of investigation and prevention of fraud and/or plan abuse.
If there is an overpayment, I authorize the recovery of the full amount of the overpayment from any amount payable under the group benefits plan, and the exchange of personal information with other persons or organizations, including credit agencies and, where applicable, my Plan Sponsor, for that purpose.

Print Name: _____

Signature: _____

Date: _____