SHEDDON PHYSIOTHERAPY AND SPORTS CLINIC

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

INTAKE FORM

Patient First Name _____ Patient Last Name _____

Date of Birth: _____/_____/_____
DD month YYYY

Address: _____

City: _____ Prov: _____ Postal Code:_____

☐ **Accepts to receive SMS Text message appointment reminders**

Mobile Tel: _____ Home Tel: _____

☐ **I give consent for my email address to be used for appointment reminders, electronic receipts, exercises and occasional newsletters. I can opt out at any time.**

***E-mail: _____**

By adding your email, we will send you appointment reminders, your home exercises and occasional newsletters – your email will never be shared with any other organization.

How did you hear about us? ☐ **Internet / Google Search** ☐ **FaceBook / Instagram**

☐ **Friend or Family member** ☐ **Sports Team / Club – Which one? _____**

☐ **Other – Please describe _____**

Emergency Contact Name: _____

Relationship: _____

Tel: _____

Email:_____

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Health Questionnaire

1. Date of accident / injury? _____

2. Are you taking any medications? _____

3. If yes, please specify _____

4. Did you have any X-rays taken for this problem? _____ If yes, which areas _____

_____ _____ Do you know the results? _____

5. Do you have any of the following: (please check appropriate items)

- ☐ High or low blood pressure
- ☐ Thyroid problem
- ☐ Lung problem
- ☐ Cardiac problems
- ☐ Kidney problem
- ☐ Pacemaker
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Recent, unexplained weight loss
- □ Cancer (presently or in the past)
- □ Diabetes
- □ Dizziness
- □ Headaches
- □ Abdominal problem
- □ Depression
- □ Anxiety
- □ Allergies
- □ Skin problem

6. Have you ever broken a bone? _____ If yes, what bone(s) _____

7. Do you have any metal fixations, screws or plates in your body? _____

8. In the past have you had any of the following: (please check and explain)

- ☐ Major surgeries _____
- ☐ Car accidents _____
- ☐ Work or sport related injuries _____

9. Do you smoke? _____

10. Are you currently working? _____ If yes, full-time or part-time _____

11. For the ladies only --- Are you pregnant? _____ If yes, how many months? _____

I hereby confirm that the above information, to be the best of my knowledge, is correct.

Name (PRINT) _____

_____ _____

Signature Date

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

Consent to Treatment at Sheddon Physiotherapy and Sports Clinic
FOR BETTER CARE: PLEASE LET US KNOW THE NAME OF YOUR FAMILY PHYSICIAN

Family Physician: _____ _____
First name or initial Last name

Do you have a doctor's referral? ☐ YES ☐ NO (you do not require one for treatment)

☐ DO NOT CONTACT MY PHYSICIAN

CONSENT

I consent to being assessed by a Sheddon Therapist which may include treatment. I will be informed of the treatment Pros and Cons by the Sheddon Therapist and am also aware of my right to withdraw my consent, verbally, to treatment, at any time.

Date: _____

_____ _____
Patient Name (PRINT) **Patient Signature**

_____ _____
Guardian Name (PRINT) **Guardian Signature**

PLEASE READ CAREFULLY

1. 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. **Initial:** _____
   ☐I accept to receive SMS Text message appointment reminder

   ☐I accept to receive email message OR text appointment reminder

2. If any third party payer (insurance company) refuses to pay for my claim, **I accept responsibility for any unpaid balance on my account. Initial:** _____
   Without consenting to the above statement we are unable to submit electronically on your behalf.

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Informed Consent to Spinal Manipulative Therapy

Doctors of Chiropractic and Physiotherapists who use manual therapy techniques such as spinal adjustments (manipulations) are required to advise patients that there are some risks associated with such treatment. In particular, you should note:
While rare, some patients have experienced muscle strain, ligamentous sprain and rib fracture following spinal adjustments (manipulation).

There have been reported cases of injury to the vertebral artery (blood vessel located in the neck) following adjustment (manipulation) to the neck (cervical spine). Vertebral artery injuries have been known to cause stroke, sometimes with serious neurological impairment. The possibility of such injuries resulting from neck spinal adjustment (manipulation) is extremely rare and occurs almost entirely in the top-most region.

There have been rare reported cases of disc injuries following neck or low back spinal adjustment (manipulation). However, scientific study has not supported that such injuries are caused or may be caused, by spinal adjustments.

Chiropractic and Physiotherapist treatment, including spinal adjustment (manipulation) has been the subject of government reports and multi-disciplinary studies conducted over many years. These reports and studies have demonstrated treatment to be effective for spinal pains, headaches and other similar symptoms. These treatments may contribute to your overall well-being. The risk of injuries or complications from treatment is substantially lower than that associated with the other treatments, medications and procedures given for the same symptoms.

I acknowledge, I will discuss, with therapist, the nature and purpose of treatment in general and my treatment in particular as well as the content of the Consent.

I consent to the Chiropractic or Physiotherapy treatment offered or recommended to me by my therapist including spinal adjustment (if warranted). I am of legal age to give consent.

Date: _____

_____ _____
Patient Name (PRINT) **Patient Signature**

_____ _____
Guardian Name (PRINT) **Guardian Signature**

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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.

A SEPARATE DOCUMENT MUST BE COMPLETED IF YOUR INSURANCE CARRIER IS SUNLIFE

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: _____