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PHYSIOTHERAPY

Service:	Patient Fee:
Physiotherapy Initial Consultation	\$90.00
Subsequent Visit	\$60.00
Re-evaluation re: 90+ days since last treatment	\$70.00

WE ACCEPT: CASH, CHEQUE, INTERAC, VISA, MASTERCARD

The Quarry Chiropractic Clinic does not third party bill (i.e. bill your insurance on your behalf), therefore fees recoverable from extended health benefits are the patients own responsibility. **It is the policy of the Quarry Chiropractic Clinic that payment is required at the time of services rendered. No accumulation of fees is permitted.**

NOTE: IF MORE THAN 3 APPOINTMENTS ARE MISSED WITHOUT NOTIFYING THE OFFICE 24 HOURS IN ADVANCE YOU WILL BE CHARGED \$50 FOR A MISSED VISIT ALONG WITH YOUR NEXT TREATMENT FEE.

Receipts / Statements for services, when would you like it?

A receipt each visit: _____ When I ask for one: _____
End of each month: _____ December 31st: _____

Please note that it is the sole responsibility of the patient to provide payment on any denied insurance claims. By signing this document, you agree to pay in full any amount owing for services rendered in the event that your claim is denied by the insurance company.

Name: _____

Date: _____ **Signature:** _____

Quarry Chiropractic Clinic - 2560 Gerrard Street East #103, Scarborough ON M1N 1W8
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The data on this confidential form is essential if we are to tender the best professional care. We appreciate your co-operation in filing it out so that we will have accurate records. PLEASE PRINT CLEARLY – THANK YOU

Name: _____ Sex: M / F

Home address: _____

City / Town: _____ Postal code: _____

Home Phone: _____ Business: _____

Cell / Pager _____ Referred by: _____

Email address: _____ Occupation: _____

Date of Birth: day: _____ month: _____ year: _____

Family Doctor: _____ phone #: _____

Referring Specialist: _____ phone #: _____

Is this visit due to a Motor Vehicle Accident (MVA)? Yes No

Is this a WSIB case and has it been reported to your employer? Yes No

Please list any medications that you are currently taking or have taken in the past year:

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Condition	Y N Pacemaker	Y N Rheumatoid Arthritis	Y N Hepatitis	Y N Anemia
Y N High/ Low Blood Pressure	Y N Alcohol/ Drug Abuse	Y N Sinus Problems	Y N Glaucoma	Y N Kidney Problems
Y N Ulcers/ Colitis	Y N Cancer	Y N Anticoagulants	Y N Severe/ Frequent Headaches	Y N Tuberculosis
Y N Difficulty Breathing	Y N Psychiatric problems	Y N Diabetes	Y N Emphysema/ Asthma	Y N Arthritis
Y N Are you pregnant	Y N Fainting/ Seizures/ Epilepsy	Y N Stroke	Y N Artificial Bones/ Joints/ Implants	Y N Allergies
Y N Hearing loss	Y N Peripheral vasucular disease	Y N Depression/Anxiety	Y N Hemophilia	

Please list any surgeries with dates and/ or any other serious medical condition(s) not listed above:

Have you had any recent unexplained weight loss or have been feeling generally fatigued or unwell? _____

Have you ever had any fractures or dislocations? _____

Do you have any areas where you lack sensation or have decreased sensitivity to hot or cold? _____

Do you have any open wounds or areas of infection? _____

List any past serious accidents with dates: _____

- We invite you to discuss with us any questions regarding our services. The best services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.
- I understand the benefits of collaboration between my health care providers. If I were to be under the treatment/care of more than one staff member of the Quarry Chiropractic Clinic, then I authorize collaboration between parties to provide me with the best care possible.

Name _____

Signature _____ Date _____

Adult patient Parent or Guardian Spouse

MVA Intake Information

**If your injury/condition is due to a motor vehicle accident,
please fill out this form**

Date of accident: _____

Private Insurance:

Do you have private insurance: Yes No

Name of insurance company: _____

Policy #: _____

Name of person on the policy: _____

Auto Insurance

Name of insurance company: _____

Policy #: _____

Claim # for this accident: _____

Name of Adjustor: _____

Phone: _____

Fax: _____

Have you had previous treatment for injuries sustained in this
accident?

Yes No

Name of patient: _____

Signature: _____

Date: _____

WSIB Intake Information

**If your injury/condition is due to a workplace accident, please
fill out this form**

Date of accident: _____

Was it reported to your employer? _____

Name of company: _____

Address: _____

Name of Supervisor: _____

Phone number: _____

Fax: _____

Date of accident: _____

Claim #: _____

Name of Adjustor: _____

Phone: _____

Fax: _____

Name of Nurse Case Manager: _____

Phone: _____

Fax: _____

Name of patient: _____

Signature: _____

Date: _____

Informed Consent for Physiotherapy

I hereby give consent to undergo physiotherapy treatment. The physiotherapist will determine the best treatment for my particular case. This treatment may include, but is not limited to, manual therapy, modalities (such as heat/cold, TENS, ultrasound, laser, electrical muscle stimulation), active exercise, and education.

I give permission for my physiotherapist to discuss any information deemed pertinent with any third-party payers or co-treating healthcare practitioners for up to 6 months after I am discharged from physiotherapy care.

I understand that I have the opportunity to discuss any questions I may have pertaining to my condition and therapy with my physiotherapist. I understand that I may withdraw my consent for any particular treatment at any time.

Name of patient: _____

Signature of patient: _____

Date: _____

Consent to Release Information

I hereby give authorization to Quarry Chiropractic Clinic to request on my behalf the results of any diagnostic tests and/or surgical notes related to my care.

Name of patient: _____

Signature of patient: _____

Date: _____