

Patient Information Form



Balance Health Physiotherapy
129 Kent St., Suite 203
Charlottetown, PEI, C1A 1N4
(902) 370-3322

General Information

First Name _____ Last Name _____ DOB (d/m/y) ___/___/___

Male

Female

Age _____

Height _____

Weight _____

Best place to leave a message? Home Work Cell

Phone _____ Email Address: _____

Mailing Address: _____

Occupation _____

Emergency Contact _____ Relationship _____ Phone _____

Referring Physician _____ Phone _____

Family Physician _____ Phone _____

Are you currently under a Physician's care, including restrictions, for any reason? Y N

Are you currently seeing any other health care professionals? Y N

Please specify _____

Medications

List all current medications

Medication:

1. _____

2. _____

3. _____

4. _____

5. _____

Hospitalizations

(reason) _____

Operations *(starting with the most recent)*

- | | |
|----------|-------------|
| 1. _____ | Date: _____ |
| 2. _____ | Date: _____ |
| 3. _____ | Date: _____ |
| 4. _____ | Date: _____ |

Past Medical History

Please check if you currently have, or have had, any of the following conditions:

- | | |
|---|---|
| <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Osteoporosis/Skeletal health |
| <input type="checkbox"/> Fractures | <input type="checkbox"/> Carpal Tunnel |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Rheumatic fever/heart murmur |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Chest discomfort |
| <input type="checkbox"/> Heart problems/abnormalities | <input type="checkbox"/> Abnormal ECG |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Coughing up blood | <input type="checkbox"/> Stomach or intestinal problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Metal implant |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> Overweight/Obesity |
| <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Migraine or recurrent headaches |
| <input type="checkbox"/> HIV | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Smoker |
| <input type="checkbox"/> Dizziness or fainting spells | <input type="checkbox"/> Leg pain after walking short distances |
| <input type="checkbox"/> Back/neck pain/injuries | <input type="checkbox"/> Foot/ankle problems |
| <input type="checkbox"/> Knee/hip problems | <input type="checkbox"/> Lymphedema |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Lung disease |
| <input type="checkbox"/> Respiratory problems/asthma | <input type="checkbox"/> Chronic or recurrent cough |

- Disease of arteries
- Increased anxiety/depression
- Arthritis
- Epilepsy
- Bowel/Bladder problems

- Varicose veins
- Recurrent fatigue
- Swollen/stiff/painful joints
- Vision/hearing problems
- Other_____

If you checked any of the above conditions, please provide a detailed explanation and the date(s) experienced:

Privacy Policy and Information Release Authorization

Why we collect personal information

Balance Health Physiotherapists collect personal information about our patients for the purpose of providing therapeutic treatment, safe training, useful information, and timely accounting. We add patient contact details to our database to send email updates, receipts, exercise program information, promotional information, and other materials of interest. Patients may opt-out of these services at any time by automated means or by contacting our administrative staff.

What kinds of information we collect

We collect a wide variety of personal information in connection with our services. This is primarily related to contact information and medical / health history.

How we collect personal information

Most of the personal information collected by us is provided directly by the individual. In some cases, information is provided by a related organization or other health care professionals.

Confidentiality

Our clinic adheres to high standards of confidentiality and abides by the standards and ethics of the Prince Edward Island College of Physiotherapists. Your information will be accessed only by those team members involved in your care or in billing for services rendered. We will use reasonable security safeguards to protect your personal information against such risk as loss, theft, or unauthorized access.

Retention

We will keep personal information only as long as it remains necessary or relevant for the identified purposes, as required by normal business practices, or as required by law.

Electronic Storage of Health Information

We maintain your health information in an electronic form and may electronically transmit your information to third parties as required in the course of your treatment as outlined in the disclosure section below.

Disclosure

As a general rule, we only disclose information to third parties as instructed in writing by our patients. Circumstances of disclosure without consent are only those as required by law, including review by professional regulatory bodies.

I authorize Balance Health Services Inc. to collect and store my information as outlined above. I authorize the release of information pertaining to evaluation, program, and progress to my medical doctor and/or the following other appointed professionals:

Signature _____ Date _____

Balance Health Physiotherapy Fee Information

Insurance Coverage

Private Physiotherapy services are not covered under provincial health care. Most private insurance plans will reimburse a percentage or a set amount of fees per year. Some plans will require a physician's referral. At Balance Health Physiotherapy we do NOT direct bill your insurance company. You are required to pay for your treatments at the time of service then submit to your insurance company for reimbursement. We will gladly provide you with the information you need to complete your insurance company's claim forms. Your insurance company will supply you with any forms needed to submit your claim. Plans do vary considerably. PLEASE CHECK YOUR INSURANCE PLAN TO DETERMINE THE AMOUNT OF COVERAGE YOU HAVE AND THE TERMS OF REIMBURSEMENT.

We accept cash, cheques, debit, Mastercard, and Visa as methods of payment.

Treatment Fees

Following your assessment, the therapist will discuss the number and frequency of treatments recommended. PAYMENT IS DUE AT THE END OF EACH TREATMENT SESSION AND CAN BE MADE BY CASH, CHEQUE, DEBIT, VISA OR MASTERCARD.

Fee Schedule

Physiotherapy Assessment (approx. 1 hr.)	\$80
Physiotherapy Treatment (approx. 30-40 min)	\$55
Running Assessment (approx. 90 min)	\$150

Missed Appointment and Cancellation Policy

We require 24 hours' notice for cancellation of appointments. As we have set aside the full appointment time for you, if you cancel without adequate notice, or if you do not arrive for your appointment you will be billed a \$35 cancellation fee. Please note that insurance plans do NOT reimburse missed appointments. If you arrive late for your appointment, this may decrease the length of your treatment session, in order to respect the next patient's scheduled appointment time.

Balance Health Physiotherapy Sensitive Practice Policy

Your comfort with Physiotherapy and your Physiotherapist is a priority for us. We are committed to the following sensitive practice guidelines in order to ensure your comfort with your care at Balance Health Physiotherapy:

You can choose to have someone accompany you during your physical therapy appointments.

This person can be a family member or friend or another person of your choice.

Physiotherapy works best when you and your therapist work as a team. For example, your Physiotherapist will explain your treatment to you. Please tell your Physiotherapist if:

- you are not comfortable with the treatment.
- you do not understand the treatment or language your therapist is using.
- you do not agree with the treatment.

Also, Physiotherapy works best when you talk to your Physiotherapist about how the treatment is working (or not working!) for you. The more you are able to tell your Physiotherapist, the better he or she will be able to help you.

We will do our best to ensure your privacy.

- In some cases, your Physiotherapist may need you to expose a part of your body for treatment (acupuncture treatment or taping, etc...). Most treatment can be provided if you wear loose fitting clothing (shorts and t-shirt) that you can bring from home. If you are not comfortable with any treatment option, please tell your Physiotherapist.
- In the event that it is necessary to change your clothing for your treatment, you will have privacy to change your clothing.

Physiotherapy involves touch and movement of your body. Your Physiotherapist will need to use his or her hands to touch and move your body to perform assessment and treatment.

Please tell your Physiotherapist if:

- certain parts of your body are sensitive to touch or movement.
- you are nervous about touch.
- there is something your Physiotherapist can do to make you more comfortable.

You have the right to stop treatment at any time, during or after a session.

Reasons people might stop treatment may include:

- discomfort during treatment.
- deciding to try a different type of medical care.

If you decide to try a different type of care, your Physiotherapist may be able to give you the name of someone she or he thinks can help you.

Above all, we want you to notice an improvement in your health.

Balance Health Physiotherapy Informed Consent Form

Please read the following statements and sign below.

- I must inform this office of any other practitioner (other than physicians) that I am currently seeing.
- I must inform my physiotherapist of any contagious or infectious condition that I might have.
- I understand that I need to express all of my health concerns (both current and past) to my physiotherapist.
- I understand and agree that my health information will be maintained by Balance Health Physiotherapy in an electronic form and may be electronically transmitted to third parties as required in the course of my treatment.
- I consent to an examination and treatment performed by a licensed physiotherapist. The results will assist the physiotherapist in determining the appropriate physical treatment to meet my specific needs and goals. I understand that the treating physiotherapist will discuss the treatment plan, including potential risks and benefits of specific treatments, and the frequency of treatment recommended.
- I understand that discomfort may occur following treatment. The therapist will contact my physician should the presence of symptoms represent any potential risks. I understand that it is my responsibility to contact a therapist in the clinic should I experience any unusual symptoms.
- I understand that if at any time I am not comfortable with, and/or do not understand the purpose of any treatment procedure I will ask the physiotherapist for further explanation/information. I understand that I may stop the assessment or treatment procedure at any time, during or after a session.

I have read, understood, and had opportunity to discuss the Patient Information form, the Privacy Policy and Information Release Authorization form, the clinic's fee structure, and the Sensitive Practice Policy.

I request that a copy of my initial assessment and follow-up report(s) be sent to my physician:

YES NO

My signature below indicates my understanding of all of the above information.

Patient Signature _____ Date: _____

Therapist Signature _____ Date: _____

If under 16 years of age, the following section of the consent form must be completed by a parent or guardian before treatment can be initiated.

I have read and fully understand all of the above information and give my permission to have

_____ assessed and/or treated at Balance Health Physiotherapy.

Parent Signature _____ Date: _____

Therapist Signature _____ Date: _____