EAST HILLS Physiotherapy

MASSAGE-Patient Intake Form

Personal

Please Read & fill in all information in details

☐ All the information in this section has not changed since my last visit. Please proceed to the Referral Section below.

First Name _____ **Last Name** _____ **Date of Birth** _____ **(Mm/dd/yy)**

Current Address _____

City _____ **Province** _____ **Postal Code:** _____

Email Address **Home Phone** **Alternative Phone #:** **Cell** **Work**

Health Card No _____ **Gender: Male / Female**

Emergency Contact Person Relationship Phone

Coverage & Referral:

Extended Health Care: (ex: Alberta Blue Cross or other) MVA WCB Law Firm Self Pay

How did you hear about us: ☐ Genesis Community Centre, ☐ Google, ☐ Radio _____ ☐ Physician _____
☐ Friends/Relatives (full name) _____ ☐ Newspaper/Magazine _____ ☐ Other _____

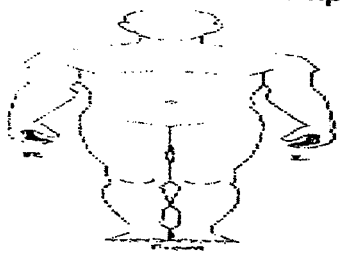
Physician Details:

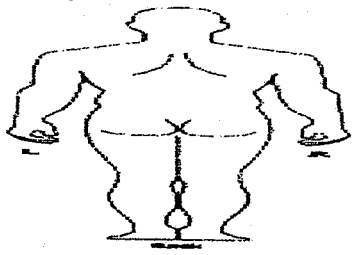
Family Physician Full Name: _____ Clinic Name & Number _____

Health & General Information

Is this your first massage? Yes / No
What brings you in for massage? Stress/pain relief/tension/other _____
Do you know the cause of pain and how long you had the pain? _____
Is there something that relieves and aggravates the pain? _____
Have you seen your family doctor about this particular problem? _____
What is your primary **complaint (or body part injury or pain)**? _____

Please Circle areas Complaint (if any)





For Prenatal Clients only - Please Fill in What Applies To You:

I am not sure if I am pregnant I am pregnant This is my 1st, 2nd or _____ Pregnancy
I am _____ (number) week in my _____ (1st, 2nd, 3rd) trimester
Have you had massage before during Pregnancy? Yes / No
Have you consult your Physician about potential benefits and risks of prenatal massage. YES / NO
Please read the Consent for Prenatal Massage

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MASSAGE-Patient Intake Form

Consent

Consent for Treatment

_____ I understand that Massage Therapy I receive is provided for the basic purpose of **relaxation, stress reduction and relief of muscular tension.** I further understand that Massage Therapy should not be interpreted as a substitute for medical examination, diagnosis, or treatment and if that then should consult by a physician or other qualified medical specialist for any mental or physical ailment that I am aware of.

_____ I Understand that Massage Therapist is not qualified to perform skeletal adjustments, diagnose and/or prescribe, and that nothing in the course of the session should be interpreted as such.

_____ I affirm that I have stated all my medical conditions and answers to all questions honestly and to the best of my knowledge. I agree to inform my Massage therapist of any updates to my medical profile and understand that there be no liability on the therapist's part if I either forgot or didn't mentioned.

Patient/Parent/Guardian Signature: _____ **Date:** _____
If you are under the age of 18, Parent/Guardian must sign

Representative Witness Signature: _____ Date: _____

Consent for Prenatal Massage – Please read and sign
_____, I understand and voluntarily consent to receive massage therapy while understanding all possible risk (if any).
_____, I verify that I have stated all my known medical conditions and risks with my massage therapist.
_____, I understand and have consulted my physician about any possible risks and benefits of prenatal massage therapy whether I am at low-risk/high-risk.

Medical Records Consent

Release of Medical Record:
I authorize East Hills Physiotherapy to **Release or Request** any information from **Physicians, Diagnostic Centers, Insurance Companies, Employers, and Law Firms** with respect to my care.

Patient/Parent/Guardian Signature: _____ **Date:** _____
If you are under the age of 18, Parent/Guardian must sign

Billing & Payment

Payment for Service Acknowledgement
I authorize East Hills Physiotherapy to submit claims on **my behalf** to my insurance company and I am responsible to pay any co-payment or any outstanding balance for my physiotherapy & Massage services at each time of the appointment upon arrival. In the event my insurance company denies the payment for any reason, **I would be responsible to pay for my physiotherapy & Massage services.**
OR
If the client **does not** carry any insurance coverage, than Client is **fully responsible** to pay the complete fee amount for his/her Physiotherapy / Massage services at each time of the appointment upon arrival.

Patient/Parent/Guardian Signature: _____ **Date:** _____
If you are under the age of 18, Parent/Guardian must sign

Cancellation Policy

Please provide **24 HOURS** cancellation notice for all **Physiotherapy / Massage** appointments. We reserve the right to charge the cancellation fee for all cancelled or missed appointments without **24 Hours'** notice.

Please note that your Insurance is not responsible to cover the cost of the cancellation fees.

PHYSIOTHERAPY CANCELLATION FEE: **Per Session** $30

MASSAGE CANCELLATION FEE: **(30 Minutes --- $25)** **(45 Minutes --- $32)** **(60 Minutes ---$40)** **(90 Minutes --- $60)**

I have read, understood and agreed to the cancellation policy as stated above.

Patient/Parent/Guardian Signature: _____

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