198 Barton Street • Stoney Creek, Ontario • L8E 2K2
t: 905 930 7876 f: 905 930 8886 e: frontdesk@absoluterw.com

Patient Name:	**Primary Insurance Co:**
Date of Birth: mm/dd/yyy:	Group Policy #
Home Address:	ID #
City: Postal Code:	Name of Insured:
Phone # : Cell # :	Date of Birth of Insured: mm / dd / yyyy
Email :	
Employer: Occupation:	
Work Phone # : Work Fax #:	
Family Doctor: **EMERGENCY CONTACT:** Referral Source: Phone #:	
Doctor Phone # : Doctor Fax # :	

OFFICE POLICIES AND PROCEDURES

APPOINTMENTS: Please be 5 – 10 minutes early and sign in for each of your appointments.

Late arrivals exceeding scheduled time by greater than 15 minutes will be re-scheduled.

Book your appointments at the beginning of each week for the following week.

Cancel your appointment if you are unable to attend, if you miss several appointments without reason, we may notify your physician or insurance company and you may be discharged.

Cancelled appointments or no show appointments, will result in a $50 dollar charge, if the clinic is not notified a minimum of 24 hrs prior.

Hours of Operation: Monday – Thursday 7-7, Friday 7-4:30

SAFETY:

Wear clothing that is appropriate for exercise & treatment.

Children must be under adult supervision and are not to play with any equipment be in treatment area.

Please notify the treating therapist of any changes in your condition or if you are unsure about a treatment.

Please call for assistance immediately if you are in any discomfort during your treatment.

If you have inhalers or nitro spray, please have it with you at all times while in the clinic

WORKERS SAFETY AND INSURANCE BOARD (WISB):

A physician's referral is recommended in case of rejection.

NOTE: If your claim is rejected, you are responsible for **ALL** fees accumulated during treatment.

MOTOR VEHICLE ACCIDENT (MVA):

A physician's referral is recommended.

The Accident Benefits Package (ABP) must be submitted to your insurance company as soon as possible (if you require assistance in completing the ABP, notify your treating therapist).

Any no show appointments will be charged the full visit fee.

NOTE: we are required by law, to bill any extended health plan you have before billing your car insurance company.

EXTENDED HEALTH CARRIER / THIRD PARTY BILLING:

Assessment fee is **$120.00 and is approximately 1 hour in length. One may or may not receive treatment on this day; treatment is dependent on how much is involved**. A Standard treatment (15 min of focused care) is **$80.** ½ hour (30 mins) of 1 on 1 treatment is **$160.** 1 hour one on one treatment is **$320.** Shockwave treatment sessions are $100.00 per session. Please speak to your provider to clarify which option is most beneficial for you.

Payment must be provided per visit. Please ask the reception for payment methods.

Once payment has been received, if you require, administration will print corresponding claim forms for you to mail out and receive reimbursement directly from your insurance company. This will ensure that the claim form is correctly filled out and the respective insurance company sends you proper reimbursement.

PRIVATE PAYMENT:

A physician referral is recommended.

Assessment fee is **$120.00,** for subsequent treatment fees, please discuss with your provider.

Payment must be provided per visit. Please ask the reception for payment methods.

NOTE: If finances are an issue, please, discuss strategies to assist in your unique situation with the treating therapist

I have read and understand the above policies & procedures. I consent to the collection, use and disclosure of my personal information. The purpose of this collection is to provide assessment and treatment services relevant to my needs and to obtain information related to payment for services provided. The information collected may be disclosed to my referring or funding agency and discussed among my treatment team.

Signature: _____ ___ **Date:** _____

ABSOLUTE rehabilitation + wellness

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Please check off accordingly: **C** = Current **P** = Past **For practitioner**: 4+ Current MB or 6+ Past MB, please refer to ND

Injury Date: MMDDYYYY
Nature of injury:
MVA/WSIB/Other_____

General History	**C**	**P**
Trauma	□	□
Fever/Chills	□	□
Allergies(MB)	□	□
Malaise/Fatigue(MB)	□	□
Weakness(MB)	□	□

Medications (List Below)
_____
_____
Surgeries (List Below – INCLUDE ANY DENTAL WORK/AMALGUM FILLINGS) _____

Family History	**C**	**P**
Diabetes	□	□
Thyroid Disease	□	□
Tuberculosis	□	□
Kidney Disease	□	□
↑ or ↓Blood Pressure	□	□
Heart Disease/Stroke	□	□
Musculoskeletal disease	□	□
Cancer	□	□

Other _____

Endocrine System	**C**	**P**
Heat/Cold Intolerance	□	□
Thyroid Problems(MB)	□	□
Diabetes(MB)	□	□

Other _____

Eye/Ear/Nose/Throat	**C**	**P**
Visual Problems	□	□
Pain in eyes	□	□
Difficulty Hearing	□	□
Ringing in Ears	□	□
Dizziness	□	□
Ear Pain	□	□
Ear Discharge	□	□
Change in Smell	□	□
Sinusitis(MB)	□	□
Hoarseness	□	□
Difficulty Swallowing	□	□
Change in Taste	□	□

Other _____

Genito-Urinary System	**C**	**P**
Pain on Urination	□	□
Change in Urine Colour	□	□
Difficulty Starting Stream	□	□
Difficulty Holding Urine	□	□
Urinary Tract Infection(MB)	□	□
Kidney Disease	□	□
Flank Pain	□	□
Prostate Problem	□	□

Other _____

Gastrointestinal System	**C**	**P**
Peptic Ulcer(MB)	□	□
Nausea/Vomiting(MB)	□	□
Indigestion/heartburn(MB)	□	□
Abdominal Pain(MB)	□	□
Abdominal Swelling	□	□
Constipation(MB)	□	□
Diarrhea(MB)	□	□
Hemorrhoids(MB)	□	□
Hernia	□	□
Gall Bladder Disease	□	□
Liver Disease	□	□
Pancreatitis	□	□
Alcohol Intake	□	□

Other _____

Respiratory System	**C**	**P**
Difficulty Breathing	□	□
Cough	□	□
Wheezing/Asthma(MB)	□	□
Tuberculosis exposure	□	□
Pneumonia	□	□
Lung Infections	□	□
Emphysema	□	□

Do you smoke □ yes □ no _Packs/day
Other _____

Cardiovascular System	**C**	**P**
Shortness of Breath	□	□
Chest Discomfort/Pain	□	□
Arm Discomfort/Pain	□	□
Palpitations	□	□
Edema/Swelling	□	□
Fainting	□	□
Sudden calf pain when walking	□	□
Heart Disease	□	□
High/Low blood pressure	□	□
Rheumatic Fever	□	□

Do you have a pacemaker? Yes□/No□
Other _____

Skin/Hair/Nails	**C**	**P**
Change in Skin Temp.	□	□
Change in Skin Texture	□	□
Skin Dryness/Wetness	□	□
Rashes/Itching/Sores(MB)	□	□
Skin Growths	□	□
Mole Changes	□	□
Skin Cancer	□	□
Change in Nail Shape/Colour	□	□

Other _____

FEMALE PATIENTS ONLY
□ Onset of last period
Date:_____
□ Are you pregnant: Yes/No
Due Date: _____
□ Birth control method Indicate(MB):

Neurological System	**C**	**P**
Headaches/Migraines(MB)	□	□
Epileptic Seizures	□	□
Tics/Spasms	□	□
Dizziness/Fainting	□	□
Sensation Disturbances	□	□
Unusual Weakness	□	□
Head Trauma	□	□
Stroke	□	□

Other _____

Musculoskeletal System	**C**	**P**
Joint Stiffness	□	□
Joint Pain	□	□
Joint Swelling	□	□
Muscle Cramps	□	□
Muscle Weakness	□	□
Muscle Wasting	□	□
Neck Pain	□	□
Mid Back Pain	□	□
Low Back Pain	□	□
Sacroiliac Pain	□	□
Tailbone Pain	□	□
Arm Problem	□	□
Leg Problem	□	□
Fractures/Dislocation	□	□
Sprains/Strains	□	□

Other _____

ANY OTHER DIAGNOSED HEALTH CONDITIONS?

Herpes	□	□
HIV / AIDS	□	□
Tuberculosis (TB)	□	□
Hepatitis A/B/C	□	□

Are you currently receiving treatment from another health care professional?
Yes/No; If yes for what _____
_____
Do you feel that you currently have significant stress in your life?
□ Yes □ No
I am **optimistic** that my present problem will improve. *(Please circle one)*
1 = strongly disagree
2 = disagree
3 = no opinion
*4 = a*gree
5 = strongly agree

Date: _____
Patient Signature: _____
Provider Signature:_____

******IF NOTHING APPLIES PLEASE SIGN THE ABOVE ACKNOWLEDGING YOU ARE IN GOOD HEALTH.*********

TELUS Health

Electronic transmission authorization and 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		
First and last name or clinic name: Absolute Rehabilitation and Wellness		
Address: 198 Barton Street		
City: Stoney Creek	Province: ON	Postal code: L8E 2K2

Patient	
First name	Last name
Primary coverage insurer/payer	Primary coverage plan member name
Primary coverage policy number (also referred to as group or contract number)	
Primary coverage certificate (also referred to as member/identification number)	
(Canada Life only) secondary coverage plan member name	

Consent to collect and exchange personal information

Purpose

Personal information that we collect and disclose about you, and if applicable, is used by the insurer, and/or plan administrator of your group benefits plan, its affiliates and their service provider(s) for the purposes of assessing eligibility for your claims, underwriting, investigating, auditing and otherwise administering the group benefits plan, including the investigation of fraud and / or plan abuse and for internal data management and data analytical purposes.

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 such 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, other organizations, or service providers working with such insurer and/or plan administrator or any of the foregoing, when relevant for the above purposes.
- where applicable exchange personal information concerning any claims with any assignee of benefits payable and exchange personal information for 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 agree 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 benefits plan.

In the event there is suspicion and/or evidence of fraud and/or plan abuse concerning any 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 employer or benefit plan sponsor, for the purposes of investigation and prevention of fraud and/or benefit plan abuse. I understand that the submission of fraudulent claims is a criminal offence.

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 benefit plan sponsor, for that purpose.

If the patient is a person other than myself, I confirm that the patient has given their consent to provide their personal information for the healthcare provider and the insurer and/or plan administrator and their service provider(s) to use and disclose their personal information as set out above.

☐ **I accept the terms and conditions**

Benefit assignment form

I hereby assign benefits payable for the eligible claims to the healthcare provider responsible for submitting my claims electronically to the group benefits plan and I authorize the insurer/plan administrator to issue payment directly to such provider. In the event my claim(s) are declined by the insurer/plan administrator, I understand that I remain responsible for payment to the healthcare 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 benefit assignment form, that any benefit payment made in accordance with this benefit assignment form 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 my healthcare 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 healthcare provider.

☐ **I accept the terms and conditions**

_____ _____

Date Signature of plan member

All information contained herein is protected by privacy laws including the Personal Information Protection and Electronic Documents Act (PIPEDA) and all the corresponding provincial legislation. All users agree to protect the personal health information contained herein from unauthorized use, disclosure, loss, theft, or compromise in accordance with the above noted laws and with at least the same care employed to protect their own confidential information. Any unauthorized access, disclosure or use of this information is illegal.

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Credit Card on File Authorization Form

Please complete this form allowing Absolute Rehabilitation and Wellness to keep your credit card on file for future payments. You may elect to provide us with credit card information separately for each payment.

Information to be completed by the card holder:

Cardholder Name: _____

Card Number: _____

Card Type: Visa MasterCard

Expiration Date: _____

Security Code: _____ (3 digit code on back)

Billing Postal Code: _____

E-mail: _____

I, _____, authorize Absolute Rehabilitation and Wellness to debit my credit card, for payment of all charges arising for **no show/late cancellation fees**, **insurance deductibles/co-payments** and **any outstanding balances that have not yet been received.** Payment for the full amount of the owing balance will be debited to my credit card as services are rendered.

This authority is to remain in effect until Absolute Rehabilitation and Wellness has received written notification from me of its change or termination. This notification must be received at least thirty (30) calendar days before the next debit is scheduled to the card provided.

Absolute Rehabilitation and Wellness may not assign this authorization, whether directly or indirectly, by operation of law, change of control or otherwise, without providing at least 30 days prior written notice to me.

I have certain recourse rights if any debit does not comply with this agreement. For example, I have the right to receive reimbursement for any charges that are not authorized in accordance to this agreement.

Thank you for your cooperation,

Team Absolute Rehabilitation and Wellness.