

PERSONAL

*** Please read and fill in all information in detail ***

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

First Name: _____ Last Name: _____ Date of birth: _____
(mm/dd/yy)

Current Address: _____

City: _____ Province: _____ Postal Code: _____

Email Address _____ Home Phone _____ Alternate Phone: ☐ Cell ☐ Work

Health Card No.: _____ Gender: ☐ Male ☐ Female

Emergency Contact Person _____ Relationship _____ Phone _____

PHYSICIAN DETAILS

Family Physician (full name): _____ Phone: _____

COVERAGE & REFERRAL

☐ Extended Health Care ☐ MVA ☐ WCB ☐ Law Firm ☐ Self Pay ☐ PCN ☐ Other _____

How did you hear about us? ☐ Genesis Community Centre ☐ Google ☐ Radio/Newspaper _____

☐ Physician _____ ☐ Friends/Relatives (full name) _____ ☐ Other _____

HEALTH & GENERAL INFORMATION

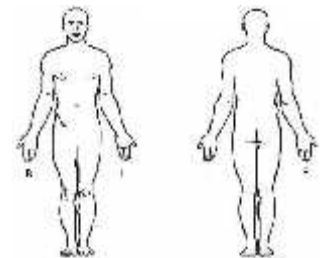
Is this your first massage? ☐ Yes ☐ No

What brings you in for massage? ☐ Stress ☐ Pain relief ☐ Tension ☐ Other: _____

Is there something that relieves and/or aggravates the pain? _____

Have you seen your family doctor about this particular problem? ☐ Yes ☐ No

Primary complaint (or body part injury or pain): _____
_____ (please circle areas of complaint, if any)



PRENATAL CLIENTS

☐ I am not sure if I am pregnant ☐ I am pregnant

This is my 1st / 2nd or _____ pregnancy.

I am _____ (number) week(s) into my ☐ 1st ☐ 2nd ☐ 3rd trimester.

Have you had massage before during Pregnancy? ☐ Yes ☐ No

Have you consulted your Physician about potential benefits and risks of prenatal massage? ☐ Yes ☐ No

Anything else you would like your therapist to know? _____

CONSENT FOR TREATMENT

_____ (initials) 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 I should consult a physician or other qualified medical specialist for any mental or physical ailment that I may be suffering.

_____ (initials) I understand that a 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.

_____ (initials) 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 will be no liability on the therapist's part if I either forgot or didn't mention medical conditions and/or medical profile updates.

Patient/Parent/Guardian Signature*: _____ **Date:** _____

Representative Witness Signature: _____ Date: _____

Consent for Prenatal Massage

_____ (initials) I voluntarily consent to receive Massage Therapy while understanding all possible risks (if any).

_____ (initials) I verify that I have stated all my known medical conditions and risks with my Massage Therapist.

_____ (initials) 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.

CONSENT FOR RELEASE OF MEDICAL RECORDS

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:** _____

BILLING & PAYMENT

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 appointment, upon arrival. In the event my insurance company denies the payment for any reason, **I would be solely responsible to pay for my Physiotherapy & Massage services.**

OR:

If I **do not** carry any insurance coverage, then I am **fully responsible** to pay the complete fee amount for my Physiotherapy & Massage services at each appointment, upon arrival.

Patient/Parent/Guardian Signature*: _____ **Date:** _____

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 for covering the cost of any cancellation fees.**

PHYSIOTHERAPY CANCELLATION FEE:

Per Session - \$30.00

MASSAGE CANCELLATION FEE:

30 min - \$25.00 / 45 min - \$32.00 / 60 min - \$40.00 / 90 min - \$60.00

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

Patient/Parent/Guardian Signature*: _____ **Date:** _____

*** If you are under the age of 18, Parent/Guardian must sign.**