CHIROPRACTIC *Health* CENTRE

Chiropractic

Thank you for choosing our team. How did you find out about us? _____

Were you referred by a patient who has seen us? Who? _____

PATIENT INFORMATION

Last Name: _____ First Name: _____ M F

Phone #: _____ (H) Address: _____

_____ (W) _____ Postal Code: _____

_____ (C) Cellular provider: --- (for text reminders)

E-mail: _____ Reminder Pref.: ☐ Phone ☐ Text ☐ E-mail ☐ None

Would you like digital receipts? Y N Would you like to receive newsletters & updates via e-mail? Y N

Birthday: _____ (mm/dd/yyyy) Marital Status: S M D W CL # of children: _____

Occupation: _____ Emergency Contact: _____

AHC #: _____ Phone #: _____

HEALTH CLAIM INFORMATION

Would you like to use direct billing?* Y N

We offer direct billing for the following companies:

Please provide the following information:

_____ Insurance Provider _____ Annual limit _____ Per visit limit

_____ Name on Card _____ Deductible _____ Rollover date

_____ ID #

_____ Group/Policy/Contract #

*Please note:

Providing your insurance information does not guarantee coverage. Eligible amounts and period of coverage are determined by your plan provider; any amount not covered by your plan must be paid upon services rendered.

Desjardins only allows for the plan member to receive reimbursement, therefore all fees incurred are still the patient's responsibility.

If you are here for a **claim**, please specify what type: ☐ MVA ☐ WCB

TODAY'S VISIT

Reason for appointment: _____

How long have you had symptoms? _____

How frequent are your symptoms? _____

Have you experienced similar symptoms in the past? Y N

Is this **condition** related to: ☐ Auto ☐ Work Date of accident/injury: _____

Please list any other healthcare professionals you are seeing for this condition: _____

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Fx: (403) 277-2447
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YOUR HEALTH HISTORY

If anything in this section doesn't apply to you, please put N/A in the space provided.

Have you had previous chiropractic care? **Y** **N** Doctor's name: _____

Do you have a family doctor? **Y** **N** Doctor's name: _____

Have you had X-Rays, MRI or other tests for this condition? **Y** **N** When? _____ Where? _____

Please list any surgeries and their dates: _____

Please list any major injuries or illnesses and their dates: _____

_____

Please list ALL medications you are taking (Prescription & Non-prescription):

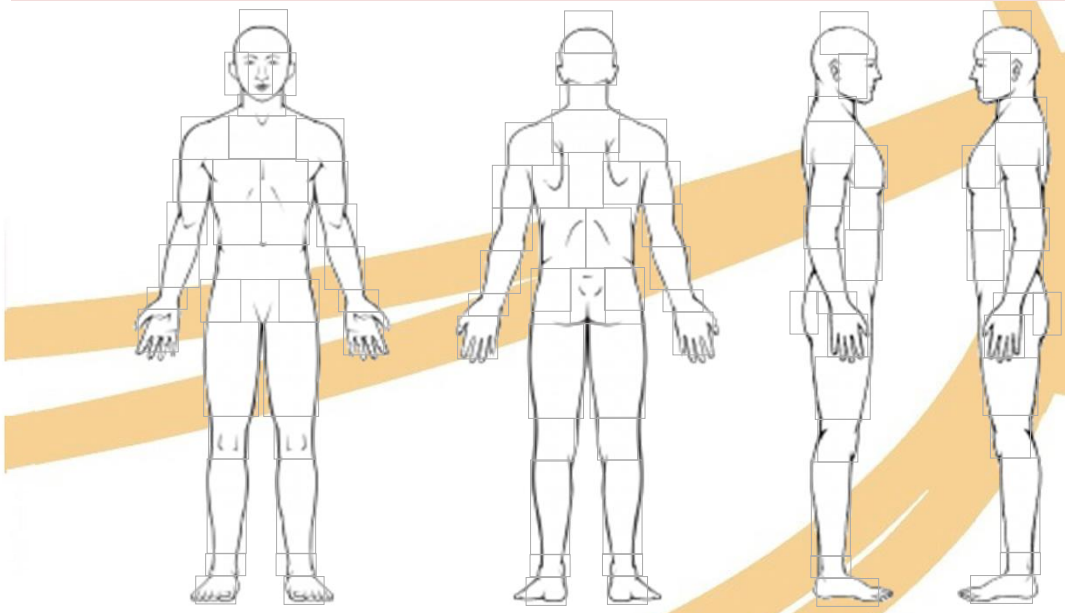
_____

_____

These conditions are extremely important to your chiropractic care.

Please be thorough. Mark whether you've experienced these conditions in the past and/or are presently.

Past	Present		Past	Present		Past	Present	
☐	☐	Low blood pressure	☐	☐	Fainting	☐	☐	Whiplash injury
☐	☐	High blood pressure	☐	☐	Smoker	☐	☐	Hardening of arteries
☐	☐	Diabetes			For how long? _____	☐	☐	Visual disturbances
☐	☐	Tuberculosis	☐	☐	Speech problems	☐	☐	Hearing disturbances
☐	☐	Cancer	☐	☐	Difficulty swallowing	☐	☐	Heart or blood disease
		If yes, where? _____	☐	☐	Dizziness	☐	☐	Loss of consciousness
☐	☐	Stroke	☐	☐	Sudden collapse without loss of consciousness	☐	☐	Taking blood thinners
		Has a relative had a stroke? Who? _____	☐	☐	Numbness or weakness in the face, fingers, hands, arms, legs, or other extremities			
☐	☐	Bone spurs in neck or cervical sprain						



Indicate the location(s) where you have pain.

On a scale of 1 to 10, (1 being no pain), how severe is your pain? _____

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Chiropractic

Please mark whether you have experienced any of the symptoms in the past and/or are presently:

GENERAL SYMPTOMS

Past	Present	
☐	☐	Fever
☐	☐	Sweats
☐	☐	Sleep disturbance
☐	☐	Fatigue
☐	☐	Nervousness
☐	☐	Weight change
☐	☐	Allergies

RESPIRATORY

Past	Present	
☐	☐	Chronic cough
☐	☐	Spitting up phlegm
☐	☐	Spitting up blood
☐	☐	Chest pain
☐	☐	Wheezing
☐	☐	Difficulty breathing
☐	☐	Asthma

GENITOURINARY

Past	Present	
☐	☐	Frequent urination
☐	☐	Painful urination
☐	☐	Blood in urine
☐	☐	Pus in urine
☐	☐	Kidney infection/Kidney stones
☐	☐	Prostate trouble
☐	☐	Uncontrollable urine flow

GASTROINTESTINAL

Past	Present	
☐	☐	Poor appetite
☐	☐	Difficult digestion
☐	☐	Heartburn
☐	☐	Nausea
☐	☐	Vomiting
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Blood in stool
☐	☐	Gallbladder/jaundice
☐	☐	Colitis

CARDIOVASCULAR

Past	Present	
☐	☐	Rapid heart rate
☐	☐	Slow heart rate
☐	☐	Pain over heart
☐	☐	Swollen ankles
☐	☐	Poor circulation
☐	☐	Palpitations
☐	☐	Varicose veins
☐	☐	Cold hands or feet

NEUROLOGICAL

Past	Present	
☐	☐	Convulsions
☐	☐	Headache
☐	☐	Neuralgia (nerve pain)
☐	☐	Poor coordination
☐	☐	Weakness
☐	☐	Vertigo

EENT

Past	Present	
☐	☐	Eye pain
☐	☐	Double vision
☐	☐	Ringing in ears
☐	☐	Deafness
☐	☐	Nosebleeds
☐	☐	Trouble swallowing
☐	☐	Hoarseness
☐	☐	Sinus infection
☐	☐	Nasal drainage
☐	☐	Enlarged glands

MUSCLE & JOINT

Past	Present	
☐	☐	Neck pain
☐	☐	Low back pain
☐	☐	Arm pain
☐	☐	Shoulder pain
☐	☐	Leg pain
☐	☐	Knee pain
☐	☐	Foot pain
☐	☐	Pain between shoulders
☐	☐	Fractures
☐	☐	Swollen joints
☐	☐	Spinal curvature
☐	☐	Arthritis

WOMEN ONLY

Past	Present	
☐	☐	Hot flashes
☐	☐	Irregular cycle
☐	☐	Cramps or back pain
☐	☐	Vaginal discharge
☐	☐	Nipple discharge
☐	☐	Lumps in breast
☐	☐	Painful menstruation
☐	☐	Birth control

Type? _____

☐ ☐ Complications with pregnancy

☐ Pregnant

Weeks? _____

☐ ☐ Menopausal symptoms

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All fees incurred for treatment are payable upon services rendered.

Fee schedule is as follows:

Chiropractic		Massage	
Initial Visit			
Adult	$109	30 Minute	$50
13-17 & 65+	$89	45 Minute	$68
12 & under	$74	60 Minute	$90
Shockwave	$175	90 Minute	$125
		120 Minute	$165
Subsequent Visits		Active Isolated Stretching	$165
Adult	$65		
13-17 & 65+	$50		
12 & under	$40		
Shockwave	$125	* All prices listed are excluding GST	
Re-examinations			
Adult	$80		
13-17 & 65+	$65	Hot Stone & Cupping:	
12 & under	$55	Regular massage plus $20	
Additional Services			
Functional Integrated Acupuncture: Chiropractic treatment plus $25			

Cancellation Policy

Thank you for making us your choice in healthcare providers and we appreciate your consideration in respecting the needs of other clients by making any necessary cancellations within a timely manner. Our clinic does require 24 hours' notice for any appointment changes or cancellations. Any late cancellations or no shows will be billed for the full price of their office visit, including any patients that are unreasonably late for their appointment and require rescheduling. Please be aware that these fees will be your responsibility as they are not eligible for reimbursement through any health benefits providers. If care is suspended or terminated, any and all outstanding charges for professional services rendered to or for you will be immediately due and payable to the clinic.

Privacy Policies

We maintain a very high standard for the protection of the confidentiality and integrity of individual personal health information. If any identifying health information is to be released to us for the purposes of providing ongoing care; express written consent will be obtained. If it occurs that your health benefits service provider requires information regarding any of your appointments for any dates in the past, present or future Chiropractic Health Centre reserves the right to provide them with this information. If you have any questions regarding your privacy concerns, feel free to direct any inquiries to the front desk.

Email Communications

The use of email addresses is to only be used for birthday emails, appointment reminders and if it is a preferred method of contact or we are unable to reach you by phone. Newsletters and promotions will only be sent if authorized by yourself. Please note that at any time you may revoke your authorization for any of the above email communications.

Release of Receipts

I understand and acknowledge that receipts for service do contain some identifying information and hereby give my consent for the release of this information to myself via my chosen method, ie. printed or emailed. This is to include receipts for individual visits, as well as for any receipts required for tax purposes at year-end.

Photo Collection

The photos obtained at your initial visit are only for the use of identification purposes and the posture scans are for the purpose of charting your progress.

Re-examination

Please be aware that if you have not attended our clinic within the last **18 months** our chiropractors are required to perform a re-assessment. All associated fees are listed in the above fee schedule.

Signature of Patient (or Legal Guardian)

Printed Name of Patient (or Legal Guardian)

Date

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Canadian Chiropractic Protective Association

Informed Consent to Chiropractic Treatment, Form L

It is important for you to consider the benefits, risks and alternatives to the treatment options offered by your chiropractor and to make an informed decision about proceeding with treatment.

Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body, instrument assisted soft-tissue therapy and techniques such as massage, Shockwave Therapy and other forms of therapy including, but not limited to, electrical or light therapy and exercise.

Benefits

Chiropractic treatment has been demonstrated to be effective for complaints of the neck, back and other areas of the body caused by nerves, muscles, joints and related tissues. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility, improve function and reduce or eliminate the need for drugs or surgery.

Risks

The risks associated with chiropractic treatment vary according to each patient`s condition as well as the location and type of treatment.

The risks include:

Temporary worsening of symptoms - Usually, any increase in pre-existing symptoms of pain or stiffness with last only a few hours to a few days.

Skin irritation or burn - May occur in association with the use of some types of electrical or light therapy. skin irritation should resolve quickly. A burn may leave a permanent scar.

Sprain or strain - Typically, a muscle or ligament sprain or strain will resolve itself within a few days or weeks with some rest, protection of the area affected and other minor care.

Rib fracture - While a rib fracture is painful and can limited your activity for a period of time, it will generally heal on its own over a period of several weeks without further treatment or surgical intervention.

Injury or aggravation of a disc - Over the course of a lifetime, spinal discs may degenerate or become damaged. A disc can degenerate with aging, while disc damage can occur with common daily activities such as bending or lifting. Patients who already have a degenerated or damaged disc may or may not have symptoms. They may not know they have a problem with a disc. They may also not know their disc condition is worsening because they only experience neck or back problems once in a while.

Chiropractic treatment should not damage a disc that is not already degenerated or damaged, but if there is a pre-existing disc condition, chiropractic treatment, like many common daily activities, may aggravate the disc condition.

The consequences or disc injury or aggravating a pre-existing disc condition will vary with each patient. In the most severe cases, patient symptoms may include impaired back or neck mobility, radiating pain and numbness into the legs or arms, impaired bowel or bladder function, or impaired leg or arm function. Surgery may be needed.

Stroke - Blood flows to the brain through two sets of arteries passing through the neck. These arteries may become weakened and damaged, either over time through aging or disease, or as a result of injury. A blood clot may form in a damaged artery. All or part of the clot may break off and travel up the artery to the brain where it can interrupt blood flow and cause a stroke.

Many common activities of daily living involving ordinary neck movements have been associated with stroke resulting from damage to an artery in the neck, or a clot that already existed in the artery breaking off and travelling up to the brain.

Chiropractic treatment has also been associated with stroke. However, that association occures very infrequently, and may be explained because an artery was already damaged and the patient was progessing toward a stroke when the patient consulted the chiropractor. Present medical and scientific evidence does not establish that chiropractic treatment causes either damage to an artery or stroke.

The consequences of a stroke can be very serious, including significant impairment of vision, speech, balance and brain funtion, as well as paralysis or death.

Alternatives

Alternatives to chiropractic treatment may include consulting other health professionals. Your chiropractor may also prescribe rest without treatment, or exercise with or without treatment.

Questions or Concerns

You are encouraged to ask questions at any time regarding your assessment and treatmen. Bring any concerns you have to the chiropractor`s attention. If you are not comfortable, you may stop treatment at any time.

Please be involved in and responsible for you care. Inform your chiropractor immediately of any change in your condiiton.

DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR

I hereby acknowledge that I have discussed with the chiropractor the assessment of my condition and treatment plan. I understand the nature of the treatment to be provided to me. I have condsidered the benefits and risks or treatment, as well as the alternatives to the treatment. I hereby consent to chiropractic treatment as proposed to me.

_____	_____
Signature of Patient (or Legal Guardian)	Signature of Chiropractor
_____	_____
Printed name of Patient (or Legal Guardian)	Printed Name of Chiropractor

_____
Date

CHIROPRACTIC *Health* CENTRE

Electronic Transmission Authorization and Consent

Service Provider:
Chiropractic Health Centre

Consent for Collection and Disclosure of Personal Information

Personal information that we collect in regards to extended health care is disclosed solely for the purposes of determining eligibility and administering the benefits plan, this includes the investigation of fraud and/or plan abuse.

Authorization for the Release of Information

I confirm that I, if not the plan member, am authorized by the individual to release any information regarding them for the aforementioned purposes.

I permit Chiropractic Health Centre to collect, use, and disclose the necessary information needed in the processing of my extended health care claims.

In the event there is suspicion and/or evidence of fraud and/or plan abuse concerning any claims submitted I acknowledge and agree that my benefits provider and Chiropractic Health Centre may use and disclose any relevant personal information to each other for the purpose of investigation and prevention of fraud and/or plan abuse.

Assignment of Benefits

I agree to assign any benefits that are paid for my eligible claims to Chiropractic Health Centre and authorize my benefits provider to issue payment directly to them. In the event any submitted claim(s) are declined or only partially covered, I understand that I will remain responsible for the cost of the services rendered. If any outstanding balances occur from this and legal action becomes necessary to collect on this amount, I understand that I will be responsible for all attorney and legal fees incurred.

I understand the above terms and agree that this authorization is to apply to all eligible claim(s) submitted electronically by Chiropractic Health Centre, and that I may revoke authorization at any time by providing written notice.

I understand that providing my insurance information does not guarantee coverage and that any uncovered amount must be paid upon services rendered.

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.

_____ _____

Signature of Patient (or Legal Guardian) Printed name of Patient (or Legal Guardian)

_____

Date

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