ISM REHAB
INNOVATION SCIENCE & MEDICINE

Recommended: _____ x week for _____ weeks.

Physiotherapy Patient Intake Form

All information is retained as part of your confidential patient record

First Name: _____ *Preferred Name*: _____Last Name: _____

Date of Birth: Year_____ Month____ Day_____ Home #: _____ Cell #: _____

Email: _____ Street Address: _____ Apt/Unit#: _____

City: _____ Province: _____ Postal Code: _____ Family Physician: _____

Referring Physician: _____ Date of Surgery *(If Applicable)*: Year_____ Month____ Day_____

Emergency Contact: _____ Relationship: _____ Phone #: _____

How did you hear about us?

O *Doctor* O *Webpage* O *Social Media* O *Friend / Family* O *Google* O *Location* O *Other*

Coverage: O None O Third Party Insurance O Motor Vehicle Claim

Third Party Insurance

Provider: _____ Policy Holder Name *(as presented on card):* _____

Policy Holder Relationship: O Self O Spouse/ Domestic Partner O Parent/ Guardian

Policy Holder Date of Birth: Year_____ Month_____ Day_____ **Do you consent to electronic billing? O Yes O No**

Policy #: _____ ID/Certificate #: _____

Motor Vehicle Claim (If Applicable)

MVA Insurance Company: _____ Policy Holder: _____ O Self

Policy #: _____ Claim #: _____ Date of Accident: Year_____ Month_____Day_____

Have you submitted the Application for Accident Benefits (OCF 1)? O Yes O No

Are you currently receiving or have ever received any of the following treatments for your current condition(s)?

O Physiotherapy O Massage Therapy O Chiropractic O Acupuncture O Occupational Therapy

O Naturopathic O Podiatry/ Chiropody O Other: _____

Have you received any of the following tests in the last 3 months for your current condition?

O X-Ray O Ultrasound O MRI O CT Scan O EMG O Bone Density Scan O Other: _____

Double Sided

ISM REHAB
INNOVATION SCIENCE & MEDICINE

Recommended: _____ x week for _____ weeks.

Medical History (include year of onset):

O Pacemaker
O Heart Condition: Do you carry Nitroglycerin?
↳ O **Yes** O **No**
O High Cholesterol
O High Blood Pressure
O Osteoporosis/ Osteopenia
O Rheumatoid Arthritis
O Diabetes
O Viral Hepatitis
O Epilepsy/ Seizures
O Stroke: _____
O Cancer: _____
O Respiratory Condition: _____

O Asthma
O Chronic Fatigue/ Fibromyalgia
O Thyroid Condition
O Chest Pain
O Chronic Cough
O Bowel/ Bladder Difficulties
O Recent Falls/ Blackouts
O Hearing Impairment
O Vision Difficulties
O Swallowing Difficulties
O Dizziness/ Fainting
O Shortness of Breath
O Poor Balance

O Anxiety
O Depression
O Digestive Problems
O ADHD
O Sleeping Difficulty
O Headaches
O Pregnancy
O Allergic to Latex
O Allergies: _____
_____
_____
O Other: _____
_____

1) Do you currently smoke? O Yes O No
2) Do you drink alcohol? O Yes O No If yes, how many drinks do you consume a week? _____
3) Please list any surgeries (including internal pins/wires/artificial joints), past injuries or major dental work you've had

_____

4) Please list your current medications (may also provide us a list of your current medications)

_____

Covid- 19 Screening Questionnaire:

Do you have any of the following new or worsening symptoms or signs? Symptoms *should not* be chronic or related to other known causes or conditions.

Fever or chills	O Yes	O No
Difficulty breathing or shortness of breath	O Yes	O No
Cough	O Yes	O No
Sore throat	O Yes	O No
Runny/ stuffy nose or nasal congestion	O Yes	O No
Decrease/ loss of smell or taste	O Yes	O No
Nausea, vomiting, diarrhea, abdominal pain	O Yes	O No

Travelled outside of Canada in the past 14 days? O Yes O No

Been in close contact with a confirmed or probable case of Covid-19? O Yes O No

To the best of my knowledge, I certify that the information provided above is true and correct

_____	_____	_____
Name of Patient	**Signature**	**Date (yyyy/mm/dd)**

Double Sided ➡

ISM REHAB
INNOVATION SCIENCE & MEDICINE

Recommended: _____ x week for _____ weeks.

HEALTH CONSENT FORM

Patient Consent for Collection and Release of Information

I have had the opportunity to review ISM Rehab's privacy policy and storage of data using DataHealth with understanding how the policy applies to me. I give permission for my physicians, doctors and therapists, insurance company, WSIB, employer, lawyer, or rehabilitation counselor to discuss any medical information pertinent to this claim or injury.

I confirm that the information that I have provided about my demographic and health history is correct and if changes occur, I will notify the staff at ISM Rehab.

Treatment

I have had the chance to discuss with my physicians, doctors and therapists the risks, benefits, alternatives, and side effects of treatment for my condition. Where appropriate, my treatment may include manual therapy, modalities (e.g. heat, ice, wax, laser, ultrasound, interferential current (IFC), electrical muscle stimulation, TENS, acupuncture, dry needling, intramuscular stimulation), and active exercise. Goals of my physiotherapy treatment plan were explained to me as well as potential outcomes if I do not have the treatment. I understand that results are not guaranteed, and the therapist will not accept liability for the results of the treatment. It is my responsibility to participate in all aspects in the program and it is imperative for my success.

I agree to participate in the assessment and treatment program delineated by ISM Rehab. Any questions or concerns regarding my recommended treatment will be brought to the attention of my therapist so rational for treatment or/adjustments can be made. If deemed appropriate by my therapist, I agree to have a student or support personnel carry out my treatment plan under supervision.

I understand and agree with the above policy and I understand that I may withdraw this consent at any time.

Name of Patient _____ Date of Birth _____

Date _____ yyyy/mm/dd

Signature of Patient _____

Double Sided

ISM REHAB
INNOVATION SCIENCE & MEDICINE

Recommended: _____ x week for _____ weeks.

Benefit Assignment Form

This form must be completed when the claim payment is assigned to the provider.

Provider: ISM Rehab
Address: 506-3027 Harvester Road
City/Province: Burlington, Ontario
Postal Code: L7N 3G7
Phone Number: 905-333-5100

Patient: _____

Address: _____

City/Province: _____

Postal Code: _____

Phone Number: _____

Policy #: _____

ID/ Certificate #: _____

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

I understand that this assignment will apply to all eligible claims submitted electronically by the 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 benefits to the provider.

Name (Print): _____ Signature: _____

Date: _____

Double Sided

ISM REHAB
INNOVATION SCIENCE & MEDICINE

Recommended: _____ x week for _____ weeks.

Payment and Cancellation Policy Notice

Payment Policy:

1. **Co-payments:** Co-payments are due at the time of service. Please be prepared to make your payment upon arrival.
2. **Insurance:** We accept most major insurance plans. Please present your insurance card at your initial visit, and we will bill your insurance directly.
3. **Self-pay Patients:** For patients without insurance coverage, payment is due at the time of service. We accept cash, credit/debit cards, and cheques.
4. **Outstanding Balances:** Any outstanding balances not covered by insurance are due within 30 days of receiving your statement.

Cancellation Policy:

1. **Appointment Changes:** We kindly request a minimum of 24 hours' notice for any appointment changes or cancellations.
2. **Late Cancellations:** A fee may be applied for appointments cancelled with less than 24 hours' notice or for missed appointments without notification.

No Show Policy:

1. **First No Show:** You will receive a verbal warning from our staff. We understand that emergencies and unforeseen circumstances arise, and we appreciate your understanding.
2. **Second No Show:** A charge of $42.50 will be applied to your account. This fee helps cover the costs associated with the missed appointment.

We kindly ask for your cooperation in adhering to these guidelines. If you anticipate that you may not be able to attend your scheduled appointment, please contact us at least 24 hours in advance to reschedule.

Name (Print): _____ Signature: _____

Date: _____

Double Sided