Beaumont Wellness Centre

All information is considered confidential.

NAME: _____ DATE: _____ GENDER: M / F

DATE OF BIRTH: *dd* /*mm* /*yyyy* _____ ALBERTA HEALTH CARE #: _____

ADDRESS: _____ CITY: _____ POSTAL CODE: _____

PHONE: (H) _____ OCCUPATION: _____

(W) _____ EMAIL: _____

(C) _____ *Do you consent to confirmations or updates via email? YES / NO*

Emergency Contact: _____ Phone: _____

Family Doctor: _____ Phone: _____

How did you hear about our clinic?

_____

Is the reason you came to this clinic related to a:

A) Motor Vehicle Accident? YES / NO Date of loss: dd /mm /yyyy _____

Fee schedule:

Chiropractic	**Adult**	**Child**
Initial Assessment	$60.00	$35.00
Treatment (Adjustment only)	$45.00	$35.00
Treatment + Neuromuscular	$60.00	$45.00
Treatment + Laser	$75.00	$60.00
Treatment + Decompression	$100.00	N/A
Laser	$50.00 - $100.00	
Active Release Techniques	$75.00	N/A

Massage

30 Minute	$50.00
45 Minute	$75.00
60 Minute	$85.00
90 Minute	$115.00

Physiotherapy

Initial Assessment	$95.00
Follow-up	$60.00
Shockwave (ESWT)	$50.00 - $250.00
Decompression	$100.00

Acupuncture

Initial Visit	$120.00
Follow-up	$90.00

Psychology

60 Minute Session	$190.00

Insurance Information:

We direct bill most insurance companies (Alberta Blue Cross, Chamber of Commerce Group, Cowan, Desjardins, Equitable Life, Great West Life, Green Shield, Industrial Alliance, Johnson INC, Manulife Financial, Maximum Benefit or Johnston Group, RCMP, Standard Life, Sun Life Financial, and Veterans Affairs).

Would you like us to direct bill for our services? YES / NO Please provide reception with card information.

I hereby assign benefits payable for the eligible claims to the Provider responsible for submitting my claims electronically to the groups benefit plan, and I authorize the insurer/plan administrator to issue payment directly to the Provider. In the event my claim(s) are declined, I understand that I remain responsible for payment to the Provider.

Please Initial

Payment is required at time of treatment unless other arrangements have been made.
At all times, you are responsible for the balance of your account.
We appreciate 24 hours notice when cancelling or rebooking appointments.

Please Initial

I, the undersigned, have read the above statements and agree to them for the term of my care.

SIGNATURE: _____ DATE: *dd* /*mm* /*yyyy* _____

Beaumont Wellness Centre

Confidential Case History

Patient Name: _____ **Date:** _____

When did your symptoms start? _____

Describe your symptoms and how they began: _____

_____

How often do you experience your symptoms?

- ☐ Constantly (76 - 100% of the day)
- ☐ Frequently (51 - 75% of the day)
- ☐ Occasionally (26 - 50% of the day)
- ☐ Intermittently (0 - 25% of the day)

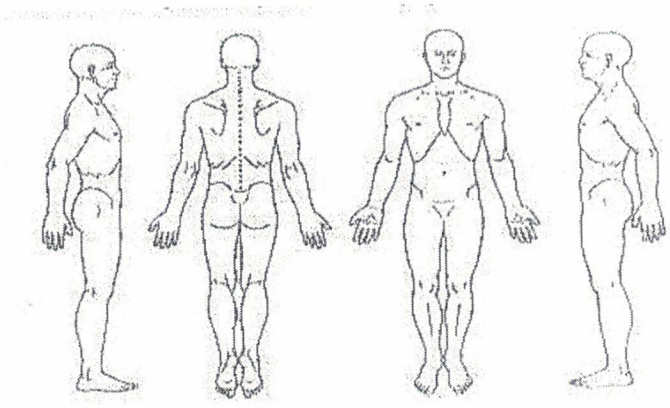
What describes the nature of your symptoms?

- ☐ Sharp
- ☐ Dull ache
- ☐ Numb
- ☐ Shooting
- ☐ Burning
- ☐ Tingling

How are your symptoms changing?

- ☐ Getting better
- ☐ Not changing
- ☐ Getting worse

Indicate where you have pain or other symptoms:



How bad are your symptoms at their:

	none										***unbearable***
worst:	0	1	2	3	4	5	6	7	8	9	10
best:	0	1	2	3	4	5	6	7	8	9	10

How do your symptoms affect your ability to perform daily activities?

0	1	2	3	4	5	6	7	8	9	10
no complaints		*mild, forgotten with activity*		*moderate, interferes with activity*		*limiting, prevents full activity*		*intense, preoccupied with seeking relief*		*severe, no activity possible*

What activities make your symptoms worse? _____

What activities make your symptoms better? _____

Who have you seen for your current symptoms?

- ☐ No one
- ☐ Chiropractor
- ☐ Medical Doctor
- ☐ Acupuncturist
- ☐ Massage Therapist
- ☐ Other

When and what treatment? _____

What tests have you had for your symptoms and when were they performed?

- ☐ X-Ray: _____ (date)
- ☐ MRI : _____ (date)
- ☐ CT Scan: _____ (date)
- ☐ Other: _____ (date)

Have you had similar symptoms in the past? ☐ Yes ☐ No

If you have received treatment in the past for the same or similar symptoms, who did you see?

- ☐ This office
- ☐ Chiropractor
- ☐ Medical Doctor
- ☐ Acupuncturist
- ☐ Other
- ☐ Massage Therapist

What do you hope to get from your treatment? (select all that apply):

- ☐ Reduce symptoms
- ☐ Resume/ increase activity
- ☐ Explanation of condition
- ☐ Learn how to care for this on my own
- ☐ How to prevent this

Confidential Case History

Name: _____ **Date:** _____

What type of regular exercise do you perform? ☐ None ☐ Light ☐ Moderate ☐ Strenuous

What is your height and weight? Height:_____ Weight: _____

For each of the conditions listed below, place a check in the *"Past"* column if you have had the condition in the past. If you presently have a condition listed below, place a check in the *"Present"* column.

Past	Present		Past	Present		Past	Present	
☐	☐	Headaches	☐	☐	High Blood Pressure	☐	☐	Diabetes
☐	☐	Neck Pain	☐	☐	Heart Attack	☐	☐	Excessive Thirst
☐	☐	Upper Back Pain	☐	☐	Chest Pains	☐	☐	Frequent Urination
☐	☐	Mid Back Pain	☐	☐	Stroke			
☐	☐	Low Back Pain	☐	☐	Angina	☐	☐	Smoking/use of tobacco products
☐	☐	Shoulder Pain	☐	☐	Kidney Stones	☐	☐	Allergies
☐	☐	Elbow/Upper Arm Pain	☐	☐	Kidney Disorders	☐	☐	Depression
☐	☐	Wrist Pain	☐	☐	Bladder Infection	☐	☐	Systemic Lupus
☐	☐	Hand Pain	☐	☐	Painful Urination	☐	☐	Epilepsy
			☐	☐	Loss of Bladder Control	☐	☐	Dermatitis/Eczema/Rash
☐	☐	Hip/Upper Leg Pain	☐	☐	Prostate Problems	☐	☐	HIV/AIDS
☐	☐	Knee/Lower Leg Pain				☐	☐	Hepatitis A
☐	☐	Ankle/Foot Pain	☐	☐	Abnormal Weight Gain/Loss	☐	☐	Hepatitis B
			☐	☐	Loss of Appetite	☐	☐	Hepatitis C
☐	☐	Jaw Pain	☐	☐	Abdominal Pain	**Females Only:**		
			☐	☐	Ulcer			
☐	☐	Joint Swelling/Stiffness				☐	☐	Birth Control
☐	☐	Arthritis	☐	☐	Liver/Gall Bladder Disorder	☐	☐	Hormonal Replacement
☐	☐	Rheumatoid Arthritis				☐	☐	Pregnancy
			☐	☐	Cancer			
☐	☐	General Fatigue	☐	☐	Tumor			
☐	☐	Dizziness	☐	☐	Asthma			
☐	☐	Visual Disturbances	☐	☐	Chronic Sinusitis			

Indicate if an immediate family member has had any of the following:

☐ Rheumatoid Arthritis ☐ Heart Problems ☐ Diabetes ☐ Cancer ☐ Lupus ☐ Other: _____

List all prescriptions and over-the-counter medications and nutritional/herbal supplements you are taking:

_____

_____

List all the surgical procedures you have had and the times you have been hospitalized:

_____

_____

Authorization

I certify that I have read, understand and accurately answered the above information to the best of my knowledge. I understand that omitting information or providing inaccurate information can be dangerous to my health.

Patient signature: _____ **Date:** _____

Doctor/Therapist signature:_____ **Date:** _____

Beaumont Wellness Centre

Patient Notification

This consent is a requirement of the Personal Information Protection Act (PIPA) passed by the Federal Government as of January 2004. If you have any concern regarding this requirement, please contact your Member of Parliament. Unfortunately, we cannot provide treatment without completion of this form.

CONSENT TO SHARE PRIVATE INFORMATION

We are committed to protecting the privacy of our patients' personal information and utilizing all personal information in a responsible and professional manner. This document summarizes some of the personal information we collect, use and disclose. In addition to the circumstances described in this from, we also collect, use and disclose personal information when permitted or required by law.

We collect information from our patients such as names, home, work, and e-mail addresses; as well as home, work, mobile and cellular telephone numbers (collectively referred to as "Contact Information"). Contact Information is collected and used for the following purposes:

- To create and update patient files.
- To invoice patients for medical services, process credit card payments or collect unpaid accounts.
- To process claims for payment or imbursement from third-party health benefit providers and insurance companies.
- To send reminders to patients concerning the need for further examination or treatment.
- To send patients informational material about our practice and services.

Contact Information is disclosed to third party health benefit providers and insurance companies where the patient has submitted a claim for reimbursement or payment of all or part of the cost of treatment or has asked us to submit a claim on the patients' behalf.

We collect information from our patients about health history, family health history and physical condition (collectively referred to as "Medical Information"). Patient Medical Information is collected and used for the purpose of diagnosing health conditions for determining a patients' suitability for treatment and providing medical treatment, if indicated.

Suite 110 - 6202 - 29 Ave
Beaumont, AB T4X 0H5
Phone (780)737-2006

Physiotherapy Consent Form

Beaumont Wellness Centre

Dear Patient,

Physiotherapy involves various types of physical evaluations and treatments. As with all forms of medical treatment, there are benefits and risks involved. The physical response to treatment varies and cannot always be predicted as every individual is different. There is no guarantee that the treatment will help the condition you are seeking to heal. There is a risk that treatment will cause some discomfort or aggravation of the existing condition.

During your physiotherapy visit, it is often necessary to expose and touch the area in need of treatment. Every effort is made to preserve modesty and keep you comfortable. Please communicate to your therapist if you have any concerns during the treatment.

By signing this, I hereby consent to the rendering of a physiotherapy evaluation and treatments as deemed appropriate by the treating therapist. I have the right to decline treatment at any time. The therapist will explain your physiotherapy diagnosis and discuss the treatment recommendations with you. Physiotherapy, as with any type of medical care, is the most effective if you participate according to the treatment plan agreed upon with your therapist. If at any given time you have questions regarding treatment and services provided, please do not hesitate to talk to your therapist.

☐ I authorize the release of all necessary information to my primary care provider and/or physician.

☐ I authorize the release of information to _____ in regards to my care or status.

☐ I have read this form and agree to all consent regarding physical therapy evaluation and treatments.

Signature: _____ Date: _____

Suite 110 - 6202 - 29 Ave • Beaumont, AB • T4X 0H5
Ph: (780) 737 - 2006 Email: beaumontwellness@gmail.com

Shockwave Therapy Consent Form

Beaumont Wellness Centre

Dear Patient,

Persisting soft tissue pain, which has not responded to conventional therapy, may improve through Extracorporeal Shockwave Therapy (ESWT) treatment. This procedure may have local side effects such as local pain, bruising and minor swelling, but are usually well tolerated and transient. If you are not able to tolerate treatment of the painful area, a local anesthetic, under the doctor's direction, may have to be administered.

This process involves the placement of a small hand-held device that applies a pneumatic-driven shockwave to the area in pain. During the procedure, it is expected that you will be able to identify the well-localized area with the maximum discomfort elicited by the application of shockwaves. A pre-defined number of shockwaves are delivered to the area of greatest sensitivity. Local swelling and discomfort are often experienced 24 to 48 hours after the treatment and slow improvement is expected (often 10-12 weeks) for plantar fascial injuries).

Do not practice any aggressive sports or other intense activities immediately after treatment due to immediate analgesic effects of the procedure and this could cause injuries as a result of overstrain.

Please check off the statements below and sign and date the document, indicating you are comfortable proceeding with the ESWT treatment.

- ☐ I understand about ESWT for my specific problem.
- ☐ I understand the contraindications and possible adverse side effects of ESWT on the patient information sheet.
- ☐ I will document my progress and provide feedback to my health professional.

Signature: _____ Date: _____

Witness Signature: _____ Witness Name: _____

Suite 110 - 6202 - 29 Ave • Beaumont, AB • T4X 0H5
Ph: (780) 737-2006 Email: beaumontwellness@gmail.com

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.

Consent to Collect and Exchange Personal Information

Message to the Plan member, Spouse and/or Dependent regarding Personal Information

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

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 the 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 when relevant for the above purposes.
- exchange personal information concerning any claims submitted with the plan member or a person acting on behalf of the plan member.
- 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.

Additional Consent Applicable to Plan Members Only

I confirm that I am authorized by my spouse and/or dependents, if any, to disclose personal information about them to the insurer and/or plan administrator and their service provider(s) for the purposes described above and I confirm that my spouse and/or dependents also authorize the insurer and/or plan administrator and their service provider(s) to disclose information about their claims to me, for the purposes of assessing and paying a benefit, if any, and managing the group benefits plan. I also authorize my spouse and/or dependents to assign benefit payments under the plan to the healthcare provider.

In the event there is suspicion and/or evidence of fraud and/or plan abuse concerning 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 Plan Sponsor, for the purposes of investigation and prevention of fraud and/or plan abuse.

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 Plan Sponsor, for that purpose.

Company:_____ **Plan Number:**_____ **Certificate Number:** _____

Date:_____ **Signature:**_____