



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:

Table with 4 columns: Service, Adult, Child, Price. Rows include Chiropractic, Massage, Acupuncture, and Psychology services.

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

## Confidential Case History

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

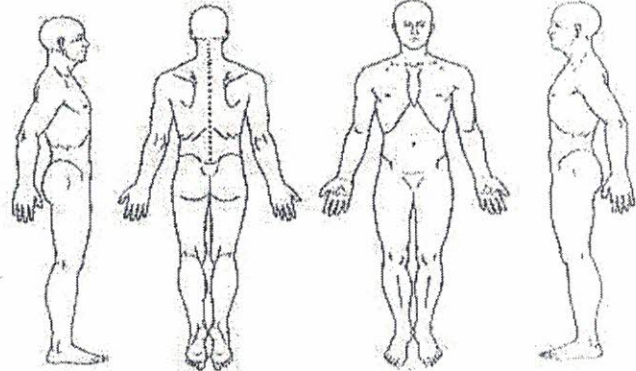
When did your symptoms start? \_\_\_\_\_

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)

Indicate where you have pain or other symptoms:



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

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
<i>no complaints</i>		<i>mild, forgotten with activity</i>		<i>moderate, interferes with activity</i>		<i>limiting, prevents full activity</i>		<i>intense, preoccupied with seeking relief</i>		<i>severe, no activity possible</i>

What activities make your symptoms worse? \_\_\_\_\_

What activities make your symptoms better? \_\_\_\_\_

Who have you seen for your current symptoms?  No one  Medical Doctor  Massage Therapist  
 Chiropractor  Acupuncturist  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  Medical Doctor  Other  
 Chiropractor  Acupuncturist  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	
<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/>	Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/>	Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Stroke			
<input type="checkbox"/>	<input type="checkbox"/>	Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Smoking/use of tobacco products
<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Elbow/Upper Arm Pain	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/>	Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/>	Hand Pain	<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
			<input type="checkbox"/>	<input type="checkbox"/>	Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/>	Dermatitis/Eczema/Rash
<input type="checkbox"/>	<input type="checkbox"/>	Hip/Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/>	Knee/Lower Leg Pain				<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A
<input type="checkbox"/>	<input type="checkbox"/>	Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Weight Gain/Loss	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B
						<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis C
<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Appetite			
			<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain			
			<input type="checkbox"/>	<input type="checkbox"/>	Ulcer			
<input type="checkbox"/>	<input type="checkbox"/>	Joint Swelling/Stiffness				<input type="checkbox"/>	<input type="checkbox"/>	Birth Control
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Liver/Gall Bladder Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Hormonal Replacement
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis				<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy
<input type="checkbox"/>	<input type="checkbox"/>	General Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Cancer			
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Tumor			
<input type="checkbox"/>	<input type="checkbox"/>	Visual Disturbances	<input type="checkbox"/>	<input type="checkbox"/>	Asthma			
			<input type="checkbox"/>	<input type="checkbox"/>	Chronic Sinusitis			

### Females Only:

<input type="checkbox"/>	<input type="checkbox"/>	Birth Control
<input type="checkbox"/>	<input type="checkbox"/>	Hormonal Replacement
<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy

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:

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

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### 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: \_\_\_\_\_

## 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:** \_\_\_\_\_

I hereby request and consent to the service of massage therapy treatment and other massage procedures, including various modes of remedial exercise and hydrotherapy, on me by the registered massage therapist.

I understand that I will have an opportunity to discuss with the massage therapist and/or with other office or clinic personnel, the nature of massage therapy treatment and other procedures. I understand the results may not be guaranteed.

I am informed that, as in all health care, in the practice of massage therapy there are some very slight risks to treatment, including, but not limited to, muscle strains and sprains, bruising, light-headed or dizziness, and tenderness. I do not expect the massage therapist to be able to anticipate and explain all risks and complications and wish to rely on the massage therapist to exercise judgment during the course of the treatment which the massage therapist feels at the time, based upon the facts then known, and is in my best interest.

I understand that I will be draped at all times and the areas undraped will be secure to ensure there is no indecent exposure. If undraping my gluteals is significant in the treatment, I do understand that it is part of the therapy.

**I am informed that I have the right to terminate the treatment at any time, and the right to alter the therapist's pressure during the massage treatment.** I am aware there are further alternatives offered at Beaumont Wellness, such as chiropractic treatment and physiotherapy. I am also aware that hot stone treatments or cupping may leave temporary red marks or bruising.

I have read the above consent. I have also had an opportunity to ask questions about its content, and by signing below, I agree to the above named procedures. I intend this consent form to cover the entire course of the treatment for my present condition and for any future condition(s) for which I seek treatment.

I also deem the answers I supplied, which are relevant to my health history, are true and accurate, and I have asked for clarification on any questions I did not understand.

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_



**Registered Massage Therapist Cancellation Policy**

If you are required to cancel a scheduled appointment with our Registered Massage Therapist, we will require a minimum of 24 hours notice. Same day cancellations will be charged 50% of the price of the scheduled service. You will be personally responsible for all cancellation charges. If you have an emergency, please let us know so that we can treat your specific situation with personal attention. We do not consider work conflicts to be emergencies.

**No Show Policy**

If you fail to call to cancel your appointment or do not show up for your scheduled appointment, you will be charged full price of the scheduled service. You will be personally responsible for all missed appointment charges.

**Late Arrival Policy**

Please arrive at least ten minutes before your scheduled appointment time in order to ensure a full massage session. Your appointment is reserved for you and have other people scheduled after your time. Your appointment will conclude at a scheduled time. If you arrive late for your appointment, it may result in you receiving a shorter massage session.

Please sign below indicating that you have received, read and understand the above policies.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_