

Welcome to Forward Physiotherapy

What we provide:

Your first appointment will involve an assessment by a Registered Physiotherapist. You will also receive a treatment, detailed explanation of the assessment findings, and a patient specific home exercise program if necessary. Prognosis and a suggested treatment plan will also be discussed.

At Forward Physiotherapy we value educating our patients. If at any point you have questions, please do not hesitate to discuss them with us in person, by email, or through our anonymous comments box.

What we need from you:

Please read the following comments thoroughly before consenting to treatment.

Please dress comfortably so you are able to fully participate in the appointment. It also may be necessary to wear a gown or shorts so that the physiotherapist is able to assess the area properly.

Forward Physiotherapy is a privately owned practice and for this reason we do not provide OHIP billing privileges. Physiotherapy may be covered by extended health care benefits provided by your employer. We do **not** deal directly with WSIB or MVA Insurance. Be sure to read through the details of your insurance coverage, as it is the patient's responsibility to understand your coverage. We will provide you with an official receipt for insurance claim purposes.

Payment for any services will be taken at the end of your appointment. Credit, debit or cash are accepted.

There is a **cancellation policy** in effect. Understandably, there may be times when you are unable to make an appointment. Please provide us with **at least 24 hours notice** so that we are able to offer your appointment time to another patient that needs it.

Please inform your therapist if you have had any related investigations done so that they can be ordered if necessary.

I have read and give my consent to the conditions above.

Name (please print)

Signature

Date

Parent/Guardian (please print)

Signature

Date

Patient Intake Form

Contact Information (Please Print)

Name: _____ **DOB (mm/dd/yyyy):** _____

Address: _____

City: _____ **Postal Code:** _____

Home #: _____ **Cell#:** _____

Email Address*: _____

**Forward Physiotherapy utilizes email to provide an ecofriendly alternative to paper receipts and home exercise programs.*

Family MD: _____ **Referring MD:** _____

Emergency #: _____ **Emergency Contact:** _____

Confidential Medical History

Cardiovascular

- Heart disease
- High/Low blood pressure
- Poor circulation
- Varicose veins
- Phlebitis
- Pacemaker
- Stroke

Respiratory

- Smoker
- Chronic cough
- Shortness of breath
- Breathing problems
- Asthma
- Bronchitis

Other

- Skin conditions
- Bruise easily
- Sinus problems
- Sleep Issues
- Cancer
- Arthritis
- Pregnant
- Seizures
- Epilepsy
- HIV/AIDS
- Repeated infections
- Thyroid problems
- Depression
- Anxiety

Digestive

- Constipation
- Irritable Bowel Syndrome
- Difficult Digestion
- Liver/Gallbladder problems
- Diabetes

Head and Neck

- Glasses
- Headaches
- Migraines
- Concussion(s)

Have you had surgery?

Surgery Type	Date	Ongoing Symptoms

Medications

Medication Name	Reason for Medication

Informed Consent

At Forward Physiotherapy, protecting your privacy and personal information is an important part of our policies and procedures. In order to provide quality care it is necessary for us to collect, use, retain, disclose and dispose of your personal health information. We do so in compliance with the College of Physiotherapist regulations and also the federal and provincial privacy legislation. We strive to be open and transparent with how we handle your personal health information.

Our privacy policy ensures the following:

- We only collect information that is applicable to your assessment and treatment.
- We only share information with your consent to do so.
- We comply with all privacy protection protocols, college regulations, as well as federal and provincial legislation.

We use and/or disclose your Personal Health Information in order to:

- Establish and maintain contact with our patients
- Assess our patients, advise patients of options, and to provide effective healthcare
- Communicate with other health care professionals who may be involved in your care
- Allow us to follow up for treatment, care, and billing
- To invoice for goods and services, process credit care payments and collect on overdue accounts
- To comply with the law and allow authorized personal to conduct an audit

Permission to Disclose Health Information

Name: _____

Date of Birth: _____

Address: _____

Postal Code: _____

Phone#: _____

Disclosing Professional(s) Name: _____

- Diagnostic reports (I.e. x-ray, MRI, CT, Bone Scan)
- Operative Protocols
- Surgical Reports
- Post Surgical Protocols
- Any other information related to my injury

I _____ authorize the disclosure of the information specified above.

Signature: _____

Date: _____