Patient Information Form

Health Skills Physiotherapy Ltd.
Suite 570, 5991 Spring Garden Road
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General Information

First Name_____ Last Name_____ DOB (d/m/y)____/____/____

☐ Male ☐ Female Age_____

Street Address_____

City_____ Province_____ Postal Code_____

Home Phone_____ Work Phone_____ Cell_____

Best place to leave a message? ☐ Home ☐ Work ☐ Cell

Email Address_____

Emergency Contact_____ Relationship_____ Phone_____

Occupation_____ Height_____ Weight_____

Referring Physician_____ Phone_____

Family Physician_____ Phone_____

Are you currently under a Physician's care, including restrictions, for any reason? ☐ Y ☐ N

Are you currently seeing any other health care professionals? ☐ Y ☐ N

Please specifiy_____

Medications

List all current medications

Medication:	Dosage:	Date started:
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

Operations (*starting with the most recent*)

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____
4. _____ Date: _____

Hospitalizations
(reason) _____

Past Medical History

Please check if you currently have, or have had, any of the following conditions:

☐	Pregnancy	☐	Osteoporosis/Skeletal health
☐	Fractures	☐	Carpal Tunnel
☐	Fibromyalgia	☐	Rheumatic fever/heart murmur
☐	High blood pressure	☐	Chest discomfort
☐	Heart problems/abnormalities	☐	Abnormal ECG
☐	Nausea	☐	Pacemaker
☐	Coughing up blood	☐	Stomach or intestinal problems
☐	Anemia	☐	Stroke
☐	Hypoglycemia	☐	Metal implant
☐	Hernia	☐	Overweight/Obesity
☐	Sleeping problems	☐	Migraine or recurrent headaches
☐	HIV	☐	Hepatitis
☐	Cancer	☐	Smoker
☐	Dizziness or fainting spells	☐	Leg pain after walking short distances
☐	Back/neck pain/injuries	☐	Foot/ankle problems
☐	Knee/hip problems	☐	Lymphedema
☐	High cholesterol	☐	Diabetes
☐	Thyroid problems	☐	Lung disease
☐	Respiratory problems/asthma	☐	Chronic or recurrent cough

Past Medical History Continued…

- ☐ Disease of arteries
- ☐ Increased anxiety/depression
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Bowel/Bladder problems
- ☐ Varicose veins
- ☐ Recurrent fatigue
- ☐ Swollen/stiff/painful joints
- ☐ Vision/hearing problems
- ☐ Other_____

If you checked any of the above conditions, please provide a detailed explanation and the date(s) experienced:

_____

_____

_____

_____

_____

_____

_____

Privacy Policy and Information Release Authorization

Why we collect personal information

Health Skills Physiotherapists collect personal information about our patients for the purpose of providing therapeutic treatment, safe training, useful information, and timely accounting. We add patient contact details to our database to send email updates, receipts, exercise program information, promotional information, and other materials of interest. Patients may opt-out of these services at any time by automated means or by contacting our administrative staff.

What kinds of information we collect

We collect a wide variety of personal information in connection with our services. This is primarily related to contact information and medical / health history.

How we collect personal information

Most of the personal information collected by us is provided directly by the individual. In some cases, information is provided by a related organization or other health care professionals.

Confidentiality

Our clinic adheres to high standards of confidentiality and abides by the standards and ethics of the Nova Scotia College of Physiotherapists. Your information will be accessed only by those team members involved in your care or in billing for services rendered. We will use reasonable security safeguards to protect your personal information against such risk as loss, theft, or unauthorized access.

Retention

We will keep personal information only as long as it remains necessary or relevant for the identified purposes, as required by normal business practices, or as required by law.

Electronic Storage of Health Information

We maintain your health information in an electronic form and may electronically transmit your information to third parties as required in the course of your treatment as outlined in the disclosure section below.

Disclosure

As a general rule, we only disclose information to third parties as instructed in writing by our patients. Circumstances of disclosure without consent are only those as required by law, including review by professional regulatory bodies.

I authorize Health Skills Physiotherapy Ltd to collect and store my information as outlined above. I authorize the release of information pertaining to evaluation, program, and progress to my medical doctor and/or the following other appointed professionals:

_____

_____

Signature _____ Date _____

Health Skills Physiotherapy Fee Information

Insurance Coverage

Physiotherapy services are not covered by MSI. Many private insurance plans will reimburse a percentage or a set amount of fees per year. Some plans will require a physician's referral. At Health Skills, we will direct bill your insurance company if you have insurance with Blue Cross. With other insurers, you will need to pay for your treatments at the time of service then submit to your insurance company for reimbursement. We will gladly provide you with the information you need to complete your insurance company's claim forms. Your insurance company will supply you with any forms needed to submit your claim. Plans do vary considerably. PLEASE CHECK YOUR INSURANCE PLAN TO DETERMINE THE AMOUNT OF COVERAGE YOU HAVE AND THE TERMS OF REIMBURSEMENT.

We accept cash, cheques, debit, Mastercard, and Visa as methods of payment.

You are responsible for co-pays and deductibles. Your co-payment, if any, must be paid at each visit throughout the course of our treatment. If a deductible is part of your policy, then you will be billed any part of your treatment that was applied to your deductible.

Treatment Fees

Following your assessment, the therapist will discuss the number and frequency of treatments recommended. PAYMENT/COPAYMENT IS DUE AT THE END OF EACH TREATMENT SESSION AND CAN BE MADE BY CASH, CHEQUE, DEBIT, VISA OR MASTERCARD.

Fee Schedule

Physiotherapy Assessment	(approx 1 hr)	$90
Physiotherapy Treatment	(approx 30 min)	$65
Physiotherapy Home Visit	(45 minutes)	$100

Missed Appointment and Cancellation Policy

We require 24 hours notice for cancellation of appointments. As we have set aside the full appointment time for you, if you cancel without adequate notice, or if you do not arrive for your appointment you will be billed for the full amount. Please note that insurance plans do NOT reimburse missed appointments. If you arrive late for your appointment, this may decrease the length of your treatment session, in order to respect the next patient's scheduled appointment time.

Health Skills Physiotherapy Sensitive Practice Policy

Your comfort with Physiotherapy and your Physiotherapist is a priority for us. We are committed to the following sensitive practice guidelines in order to ensure your comfort with your care at Health Skills Physiotherapy:

You have the right to choose a male or female physical therapist.

- If you know this is important for you, please tell us when you book your first appointment.
- If you decide later in treatment that you would rather work with a therapist of a different gender, you may tell us then too.
- If we are unable to book you with your choice of a male or female therapist, we will refer you to a facility that can if you wish.

You can choose to have someone accompany you during your physical therapy appointments. This person can be a family member or friend or another person of your choice.

Physiotherapy works best when you and your therapist work as a team. For example, your Physiotherapist will explain your treatment to you. Please tell your Physiotherapist if:

- you are not comfortable with the treatment.
- you do not understand the treatment or language your therapist is using.
- you do not agree with the treatment.

Also, Physiotherapy works best when you talk to your Physiotherapist about how the treatment is working (or not working!) for you. The more you are able to tell your Physiotherapist, the better he or she will be able to help you.

We will do our best to ensure your privacy.

- In some cases, your Physiotherapist may need you to expose a part of your body for treatment – for example with acupuncture treatment or taping, etc. Most treatment can be provided if you wear loose fitting clothing (shorts and t-shirt) that you can bring from home. If you are not comfortable with any treatment option, please tell your Physiotherapist.
- In the event that it is necessary to change your clothing for your treatment, you will have privacy to change your clothing.

Physiotherapy involves touch and movement of your body. Your Physiotherapist will need to use his or her hands to touch and move your body to perform assessment and treatment.

Please tell your Physiotherapist if:

- certain parts of your body are sensitive to touch or movement.
- you are nervous about touch.
- there is something your Physiotherapist can do to make you more comfortable.

You have the right to stop treatment at any time, during or after a session.

Reasons people might stop treatment may include:

- discomfort during treatment.
- deciding to try a different type of medical care.

If you decide to try a different type of care, your Physiotherapist may be able to give you the name of someone she or he thinks can help you.

Above all, we want you to notice an improvement in your health.

Health Skills Physiotherapy Informed Consent Form

Please read the following statements and sign below.

- I must inform this office of any other practitioner (other than physicians) that I am currently seeing.
- I must inform my physiotherapist of any contagious or infectious condition that I might have.
- I understand that I need to express all of my health concerns (both current and past) to my physiotherapist.
- I understand and agree that my health information will be maintained by Health Skills Physiotherapy in an electronic form and may be electronically transmitted to third parties as required in the course of my treatment.
- I consent to an examination and treatment performed by a licensed physiotherapist. The results will the assist the physiotherapist in determining the appropriate physical treatment to meet my specific needs and goals. I understand that the treating physiotherapist will discuss the treatment plan, including potential risks and benefits of specific treatments, and the frequency of treatment recommended.
- I understand that discomfort may occur following treatment. The therapist will contact my physician should the presence of symptoms represent any potential risks. I understand that it is my responsibility to contact a therapist in the clinic should I experience any unusual symptoms.
- I understand that if at any time I am not comfortable with, and/or do not understand the purpose of any treatment procedure I will ask the physiotherapist for further explanation/information. I understand that I may stop the assessment or treatment procedure at any time, during or after a session.

I have read, understood, and had opportunity to discuss the Patient Information form, the Privacy Policy and Information Release Authorization form, the clinic's fee structure, and the Sensitive Practice Policy.

I request that a copy of my initial assessment and follow-up report(s) be sent to my physician:

YES ☐ NO ☐

My signature below indicates my understanding of all of the above information.

Patient Signature _____ Date:_____

Therapist Signature _____Date: _____

If under 16 years of age, the following section of the consent form must be completed by a parent or guardian before treatment can be initiated.

I have read and fully understand all of the above information and give my permission to have

_____ assessed and/or treated at Health Skills Physiotherapy.

Parent Signature _____Date:_____

Therapist Signature _____Date: _____