VELOCITY

Today's Date:

PATIENT INFORMATION (Please Show Health Card to Receptionist)				
☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.	First Name	Middle Initial	Last Name	Marital Status: ☐ Sgl ☐ Mar
Birth Date (MM/DD/YR)		Age	Health Card Number (& Version Code)	
Street Address		City	Province	Postal Code
Home Telephone	Work Telephone	Cell Phone	Email Address	
Family Physician	Physician Telephone	Emergency Contact (Name/Relation/Tel#)		Occupation

ATHLETE INFORMATION:			
Sport	Team Name	Division/Level	Age Group
Coaches Name & Contact			CSCO Number

INSURANCE CLAIMS			
☐ MVA	Date of Accident	Claim Number/Policy Number	Company Claims Manager Name and Contact
☐ WSIB	SIN	Employers Name and Address	Do you have any private insurance? Company Name

HOW DID YOU HEAR ABOUT US?

☐ Website- Search Engine ☐ Drive By/Walk-In ☐ Flyer ☐ On-Site Medical Event ☐ Running Room or Runner's Mark talk _____

☐ Friend ☐ Coach ☐ Relative. If you were referred by someone in particular please let us know, so we can thank them for their support. _____

☐ Advertisement: _____

Health History

Childhood Illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chicken Pox ☐ Rheumatic Fever ☐ Polio

List Any Medical Problems That Other Doctors Have Diagnosed:

Surgeries or other Hospitalizations:

Year:	Reason:	Year	Reason:

List Your Prescribed Drugs and Over-the-Counter Drugs, Such as Vitamins and Inhalers:

HEALTH HABITS AND PERSONAL SAFETY

☐ Sedentary (No exercise) ☐ Mild Exercise (i.e., climb stairs, walk 3 blocks, golf)
☐ Occasional Vigorous Exercise (i.e., work or recreation less than 4x/week for 30 min.)
☐ Regular Vigorous Exercise (i.e., work or recreation 4x/week for 30 minutes)

OTHER PROBLEMS

☐ Skin ☐ Head/Neck ☐ Ears ☐ Nose ☐ Throat ☐ Lungs ☐ Chest/Heart	☐ Back ☐ Intestines ☐ Bladder ☐ Bowels ☐ Circulation	**Recent Changes In:** ☐ Weight ☐ Energy Level ☐ Ability to Sleep **Other Pain/Discomfort:**

Privacy Code

Privacy of personal information is important to Velocity Sports Medicine & Rehabilitation. We are committed to the collection, use and disclosure of this information in a responsible way. We will also try to be as open and transparent as to how we handle personal information.

Personal Information

Personal information is information about an identifiable individual. Generally, the information we collect is limited to your name, home contact information, gender and age. As part of your patient file we retain your health history; health measurements and examination results; health conditions, assessment results and diagnoses; the health services provided to you or received by you; your prognosis and other opinions formed; compliance with treatment; and the reasons for your discharge and discharge recommendations. We also maintain records for payment and billing purposes. Only necessary information is collected about you. We only share your information with your consent; the use, retention and destruction of your personal information complies with existing legislation and privacy protection protocols. Privacy protocols comply with privacy legislation, standards of our regulatory body, the College of Chiropractors of Ontario and the law.

Staff Members

Staff members who come into contact with your personal information are aware of the sensitive nature of the information you have disclosed to us. They are all trained in the appropriate uses and protection of your information. These individuals include the clinic records personnel that control access to your patient file, therapists, clinic administration and, when necessary, authorized individuals who may inspect our records as part of the regulatory activities in the public interest.

Disclosure of Personal Information

Our clinics understand the importance of protecting your personal information. To help you understand how we are doing that, we outline below how our clinics use and disclose this information:

- To deliver safe and effective patient care
- To enable us to contact you
- To communicate with other health care providers
- For teaching and demonstrating on an anonymous basis
- To complete and submit claims on your behalf to third party payers
- To comply with legal and regulatory requirements under the Chiropractic Act and the Regulated Health Professions Act
- To process payments and collect unpaid accounts
- For research purposes
-

Please do not hesitate to discuss our privacy policy with any member of our clinic staff.
By signing the consent section of this form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information for the purposes that are listed. If a new purpose arises for the use and/or disclosure of your personal information, we will seek your approval in advance.

Patient Consent

I have reviewed the above information that explains how our clinics will use my personal information
I agree that Velocity Sports Medicine & Rehabilitation can collect, use and disclosure my personal information as set out above in the College's privacy code.

_____	_____	_____	_____
(Signature)	(Print name)	(Date)	(witness)

VELOCITY
Sports Medicine & Rehabilitation

Patient Name (please print): _____

CONSENT TO CHIROPRACTIC TREATMENT

It is important for you to consider the benefits, risks and alternatives to the treatment options offered by your chiropractor and to make an informed decision about proceeding with treatment.

Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body, soft-tissue techniques such as massage, and other forms of therapy including, but not limited to, electrical or light therapy and exercise.

Benefits

Chiropractic treatment has been demonstrated to be effective for complaints of the neck, back and other areas of the body caused by nerves, muscles, joints and related tissues. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility, improve function, and reduce or eliminate the need for drugs or surgery.

Risks

The risks associated with chiropractic treatment vary according to each patient's condition as well as the location and type of treatment.

The risks include:

- **Temporary worsening of symptoms** – Usually, any increase in pre-existing symptoms of pain or stiffness will last only a few hours to a few days.
- **Skin irritation or burn** – Skin irritation or a burn may occur in association with the use of some types of electrical or light therapy. Skin irritation should resolve quickly. A burn may leave a permanent scar.
- **Sprain or strain** – Typically, a muscle or ligament sprain or strain will resolve itself within a few days or weeks with some rest, protection of the area affected and other minor care.
- **Rib fracture** – While a rib fracture is painful and can limit your activity for a period of time, it will generally heal on its own over a period of several weeks without further treatment or surgical intervention.
- **Injury or aggravation of a disc** – Over the course of a lifetime, spinal discs may degenerate or become damaged. A disc can degenerate with aging, while disc damage can occur with common daily activities such as bending or lifting. Patients who already have a degenerated or damaged disc may or may not have symptoms. They may not know they have a problem with a disc. They also may not know their disc condition is worsening because they only experience back or neck problems once in a while.

Chiropractic treatment should not damage a disc that is not already degenerated or damaged, but if there is a pre-existing disc condition, chiropractic treatment, like many common daily activities, may aggravate the disc condition.

The consequences of disc injury or aggravating a pre-existing disc condition will vary with each patient. In the most severe cases, patient symptoms may include impaired back or neck mobility, radiating pain and numbness into the legs or arms, impaired bowel or bladder function, or impaired leg or arm function. Surgery may be needed.

- **Stroke** – Blood flows to the brain through two sets of arteries passing through the neck. These arteries may become weakened and damaged, either over time through aging or disease, or as a result of injury. A blood clot may form in a damaged artery. All or part of the clot may break off and travel up the artery to the brain where it can interrupt blood flow and cause a stroke.

Many common activities of daily living involving ordinary neck movements have been associated with stroke resulting from damage to an artery in the neck, or a clot that already existed in the artery breaking off and travelling up to the brain.

Chiropractic treatment has also been associated with stroke. However, that association occurs very infrequently, and may be explained because an artery was already damaged and the patient was progressing toward a stroke when the patient consulted the chiropractor. Present medical and scientific evidence does not establish that chiropractic treatment causes either damage to an artery or stroke.

The consequences of a stroke can be very serious, including significant impairment of vision, speech, balance and brain function, as well as paralysis or death.

Alternatives

Alternatives to chiropractic treatment may include consulting other health professionals. Your chiropractor may also prescribe rest without treatment, or exercise with or without treatment.

Questions or Concerns

You are encouraged to ask questions at any time regarding your assessment and treatment. Bring any concerns you have to the chiropractor's attention. If you are not comfortable, you may stop treatment at any time.

DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR

I hereby acknowledge that I have discussed with the chiropractor the assessment of my condition and the treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I hereby consent to chiropractic treatment as proposed to me.

_____ Date: _____ 20____
Signature of patient (or legal guardian)

_____ Date: _____ 20____
Signature of Chiropractor

INFORMED CONSENT FOR ACUPUNCTURE

I hereby request and consent to the performance of acupuncture and other procedures related to acupuncture if necessary including needling, moxabustion, cupping, guasha, laser, electoacupunture, and other techniques within the scope of practice of acupuncturists. These procedures may be performed by the acupuncturists or another duly authorized person in the clinic.

I have had the opportunity to discuss with the acupuncturist and/or with other office or clinic personnel the nature and purpose of acupuncture care and other procedures. I understand that results are not guaranteed.

I have been advised that all insertion needles are pre-sterilized and disposable. I further understand and an informed that, as with all health care, the practice of acupuncture possess slight risks from treatment, including but not limited to temporary soreness, bruising, blistering, nausea, fainting, bleeding, infection, and shock. I do not expect acupuncturist to be able to anticipate and explain all risks and complications and I wish to rely on the acupuncturist to exercise judgment during the course of the procedures which the acupuncturist feels at the time, based upon facts then known, are in my best interest.

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

_____ **Date:**_____ _____ **Date:** _____

Patient Signature (Legal Guardian) **Witness of Signature**

FEE SCHEDULE

Initial Assessment- Chiropractic/Physiotherapy-**$140;** Follow-up-Chiropractic/Physiotherapy-**$75;** New Complaint- Chiropractic/Physiotherapy-**$110**; Massage Therapy- 30min; **$62.15**, 45 min; **$84.75**, 60 min; **$96.05**

All additional fees will be provided prior to service. Service:_____ Fee: _____ Initials: ____

24hr-Cancellation Policy: ***The full cost of the appointment will be applied to your account if less than 24 hours notice is given for cancelled appointments.***

Payment is due at the time services are rendered. For your convenience, we accept cash, Visa, and Master Card. This policy applies to all of our patients.

If you have not made payment in full or made full financial arrangements with our office, your account will be reviewed for collection. Patients having health care insurance should remember that professional services provided are the patient's responsibility, not the facility or the insurance company. **If payment is not made on a bill from our office within forty-five (45) days after the date of such bill, interest may be charged to you on the balance of such bill commencing on the forty-fifth (45) day after the date of the bill. The interest rate will be thirty percent (30%) per annum.**

Our office does **not** file insurance claims for you. However, we would be happy to provide you with the necessary documents and invoices upon complete payment of services for you to submit for reimbursement.

In cases of divorce, the parent who brings the child/children in for treatment is responsible for payment and for collecting from the other parent or attorneys.

SPECIAL SUPPLIES

Custom made knee braces or other specialty orthotics and braces will not be ordered for a patient until the patient has paid at least 50% of the item cost. We do realize that specialty braces are an expensive part of your treatment and we do make every attempt to control these costs. Our staff is available to assist patients with insurance benefit verification for such items.

If you have any further questions regarding insurance, be certain to bring in your insurance book so we can determine your coverage and avoid any confusion.

We require a credit card on file to protect against delinquent accounts. Accounts must be cleared within 30-days of service if they are not your credit card will be debited in that amount.

PAYMENT OPTION: For convenience purposes, should you like to have your account debited after each service please circle **YES**

Thank you for allowing us to be part of your health care. We want your experience with Velocity Sports Medicine & Rehabilitation to be a pleasant one and we hope this information will help to make it so. I have read Velocity Sports Medicine & Rehabilitation financial policy and understand my financial responsibility and agree to the terms stated in the Financial Policy.

I HEREBY I AGREE TO PAY ANY AND ALL CHARGES FOR SERVICES RENDERED AND ITEMS PURCHASED AT Velocity Sports Medicine & Rehabilitation.

Patient signature: **Date:**

Velocity Sports Medicine & Rehabilitation- 167 Lakeshore Road West, Mississauga, ON L5H 1G3
905.891.1999 F. 905.891.1905

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