VELOCITY
Sports Medicine & Rehabilitation

Today's Date:

PATIENT INFORMATION

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

ATHLETE INFORMATION:

Sport	Coaches Name & Contact	Division/Level	Age Group

INSURANCE COVERAGE/CLAIMS

☐ No coverage ☐ Benefits ☐ Motor Vehicle Accident (MVA) ☐ Workplace injury (WSIB)

☐ MVA	Date of Accident	Claim Number/Policy Number	Company Claims Manager's 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 ☐ Doctor ☐ Presentation ☐ Coach ☐ Advertisement: _____
☐ Family/Friend **If someone referred you in particular please let us know, so we can thank them for their support.** _____

HEALTH HISTORY

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

List Any Medical Problems That Other Doctors Have Diagnosed:

SURGERIES AND OTHER HOSPITALIZATIONS:

Year:	**Reason:**	**Year:**	**Reason:**
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 levels
☐ ability to sleep

Other pain or 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, attention 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 interests.

Disclosure of Personal Information

Our clinic understands 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.

Name (Please Print) **Patient Signature (Legal Guardian)** **Date**

Witness Signature **Date**

Informed Consent To Physiotherapy and Athletic Therapy Treatment

Doctors of chiropractic, medical doctors, and physiotherapists who use manual therapy techniques such as spinal adjustments are required to advise patients that there are or may be some risks associated with such treatment. In particular you should note:

a. While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following spinal adjustments.
b. There have been reported cases of injury to a vertebral artery following cervical spinal adjustments. Vertebral artery injuries have been known to cause strokes, sometimes with serious neurological impairment and may on rare occasion result in serious injury. The possibility of such injuries resulting from cervical spinal adjustments is extremely remote;
c. There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustments although no scientific study has ever demonstrated such injuries caused or may be caused, by spinal adjustments or chiropractic treatment

Physiotherapy treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and have been demonstrated to be highly effective treatment for spinal pain, headaches and other similar symptoms. Physiotherapy care contributes to your overall well being. The risk of injuries or complications from physiotherapy treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I acknowledge I have discussed, or have had the opportunity to discuss, with my physiotherapist the nature and purpose of physiotherapy treatment in general and my treatment in particular as well as the contents of this Consent.

I consent to the physiotherapy treatments offered or recommended to me by my physiotherapist, including spinal adjustment. I intend this consent to apply to all my present and future physiotherapy care.

Name (Please Print)	**Patient Signature (Legal Guardian)**	**Date**

Physiotherapist Signature	**Date**

Informed Consent For Acupuncture Care

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

Acupuncture involves the insertion of small sterilized needles into specific locations on the skin surface. Other procedures related to acupuncture include moxibustion, cupping and electroacupuncture.

Benefits
Acupuncture and procedures related to acupuncture have been demonstrated to be a safe and effective form of treatment for a range of conditions including musculoskeletal complaints and pain.

Risks
The risks associated with acupuncture include minor bleeding and bruising, temporary pain and soreness, nausea, fainting, burns, infection, shock, convulsions, pneumothorax, perforation of internal organs, and stuck or bent needles.

Please inform the physiotherapist if you:

- Have damaged heart valves or have a high risk of infection
- Suffer from metal allergies
- Are Immune compromised
- Have had prosthetic implants
- Have or develop any major health issues
- Are pregnant or actively trying to be
- Have been fitted for a pacemaker or other electrical implants
- Have a bleeding disorder or take anticoagulants

Only sterile single use disposable needles will be used. All acupuncture needles are properly disposed of after each and every treatment.

Pregnancy
The use of certain acupuncture points and treatment techniques may not be recommended during pregnancy. Advise your physiotherapist if you are pregnant or actively trying to be.

Alternatives
Alternatives to acupuncture treatment may include rest, exercise, other modalities or consulting other health professionals.

Questions or Concerns
You are encouraged to ask questions at any time regarding your assessment and treatment. Bring any concerns you have to the physiotherapist's attention. If you are not comfortable, you may stop treatment at any time. **Please be involved in and responsible for your care. Inform your physiotherapist immediately of any change in your condition.**

DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE PHYSIOTHERAPIST

I hereby acknowledge that I have read this form and discussed with the physiotherapist 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 acupuncture treatment as proposed to me.

_____

Name (Please Print) **Patient Signature (Legal Guardian)** **Date**

_____

Physiotherapist Signature **Date**

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 eighteen percent (18%) 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 (Legal Guardian): **Date:**

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