

Dr. Rebecca Patterson, D.C.

Natural Care Clinic

Upper Canada Place 460 Brant St. Ste. # 16 Burlington, Ontario L7R 4B6

Chiropractic intake Form

Patient Information (please print clearly)

Name: _____ Date of Birth: mm/dd/yyyy ____/____/____ Age: ____
Address: _____ City: _____ Postal Code: _____
Phone: (H) _____ (B) _____ (M) _____
Email: _____ (providing your email will enable you to receive our monthly newsletter as well as provide an alternate means of communication)
Occupation: _____ How did you find out about us? _____
Emergency Contact: (Name) _____ (Relationship) _____ (Phone number) _____

Billing Information

Is your complaint related to a motor vehicle accident? (Please circle) Yes No

If Yes, please fill in the following:

Date of accident: _____ Insurer's name: _____

Claim Number: _____ Insurer's address and telephone number: _____

Is your complaint a WSIB claim? (Please circle) Yes No

If Yes, please fill in the following:

Employer Name: _____ Social Insurance Number: _____

Employer address and telephone number: _____

Date of accident: _____ WSIB Claim Number: _____

Fee Schedule

Initial Assessment: \$75 subsequent appointment: \$35 30 minute follow-up: \$55 Acupuncture: \$55

Payment is due at the time services are rendered. For your convenience, we accept cash, cheque, debit, Visa and Mastercard. This policy applies to all of our patients. We understand that unusual circumstances may arise and that payment in full at the time of service may not always be possible. Special payment needs should be discussed by the patient and a member of the business department. Payment plans are subject to approval by the administrator and your therapist. In such cases, you will receive a monthly statement showing all charges and payments. If you have not made payment in full, or made full financial arrangements with our office, your account will be reviewed for collection. If payment is not made on a bill from our office within forty-five (45) days after the date of the 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. Patients having health care coverage should remember that professional services provided are the patient's responsibility, not the insurance company. Our office does not file insurance claims for you; however, we would be happy to help you find the necessary documents and invoices upon complete payment of services for you to submit for reimbursement.

We require 24 hours notice if you are unable to make your scheduled appointment. After an initial warning, the second and all subsequent missed appointments will be billed at the regular fee.

A 50% deposit is required prior to ordering custom-made orthotics. We do realize that custom orthotics are an expensive part of 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.

I have read the Dr. Rebecca Patterson, D.C. financial policy and understand my financial responsibility and agree to the terms stated in the Financial Policy. I HEREBY AGREE TO PAY ANY AND ALL CHARGES FOR SERVICES RENDERED AND ITEMS PURCHASED AT NATURAL CARE CLINIC.

Patient Signature: _____ Date: _____

Patient Name: _____ Date: _____

Health History

Medical Doctor: _____ Phone: _____

Previous Chiropractic care: (Name) _____ (Phone Number) _____

Current Medications (including vitamins and supplements):

Previous fractures, surgeries, or hospitalizations (Please list and date):

List any medical problems that other doctors have diagnosed: _____

List other current therapies (ie: physiotherapy, massage): _____

- Exercise level:
- Sedentary (no exercise)
 - Mild exercise (e.g. Climb stairs, walk 3 blocks, golf)
 - Occasional exercise (e.g. work or recreation less than 4x/week for 30 min)
 - Regular vigorous exercise (e.g. work or recreation 4x/week or more for 30 min)

For Women Only:

Age of onset of menstruation: _____ Date of last menstruation: _____ Length of cycle: _____

Heavy periods, irregularity, spotting, pain or discharge? Yes No

Are you pregnant or breast-feeding? Yes No

Have you had a D&C, hysterectomy, or Cesaarean section? Yes No

Any urinary tract, bladder, or kidney infections in the past year? Yes No

Any blood in your urine? Yes No

Any problems with control or urination? Yes No

Experienced any recent breast tenderness, lumps, or nipple discharge? Yes No

Date of last pap smear and rectal exam: _____

For Men Only:

Do you usually urinate during the night? Yes No If Yes, number of times: _____

Any blood in your urine? Yes No

Have you had any kidney, bladder, or prostate infections in the last 12 months? Yes No

Do you have any problems emptying your bladder completely? Yes No

Any testicle pain or swelling? Yes No

Date of last prostate and rectal exam: _____

Other Problems:		
<input type="checkbox"/> Skin <input type="checkbox"/> Head/Neck <input type="checkbox"/> Eyes <input type="checkbox"/> Ears <input type="checkbox"/> Nose <input type="checkbox"/> Throat <input type="checkbox"/> Lungs <input type="checkbox"/> Chest/Heart	<input type="checkbox"/> Back <input type="checkbox"/> Intestines <input type="checkbox"/> Bladder <input type="checkbox"/> Bowels <input type="checkbox"/> Circulation <i>Recent Changes in:</i> <input type="checkbox"/> Weight <input type="checkbox"/> Energy level <input type="checkbox"/> Sleep Patterns	<i>Other areas of pain/discomfort:</i>

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Privacy Policy

Privacy of personal information is important to YOUR HEALTH. We are committed to the collection, use and disclosure of this information in a responsible way. We will also try to be an 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; 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 privacy protection protocols. Privacy protocols comply with the 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 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 clinic will use my personal information.

I agree that Your Health Wellness Centre can collect, use, and disclose my personal information as set out above in the College's privacy code.

(Signature)

(Print name)

(Date)

(Signature of Witness)

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Informed Consent to Chiropractic Treatment

Doctors of chiropractic who use manual therapy techniques 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 may experience short term aggravation of symptoms, rib fractures or muscle and ligament strains or sprains as a result of manual therapy techniques;
- b) There are reported cases of stroke associated with many common neck movements including adjustment of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because stroke sometimes causes serious neurological impairment, and may on rare occasion result in injuries including paralysis. The possibility of such injuries resulting from upper cervical spinal adjustment is extremely remote;
- c) There are rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal adjustments or chiropractic treatment.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. Chiropractic care contributes to your overall well being. The risk of injuries or complications from chiropractic 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 chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Consent. I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

Dated this _____ day of _____, 20____

Name: (print) _____ (Signature) _____

Witness: (print) _____ (Signature) _____

Informed consent to Acupuncture

I hereby request and consent to the performance of acupuncture and other procedures related to acupuncture if necessary including needling, guasha, laser, electroacupuncture, 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 the results are not guaranteed.

I have been advised that all insertion needles are pre-sterilized and disposable. I further understand and am informed that, as with all health care, the practice of acupuncture possesses slight risks from treatment, including, but not limited to, temporary soreness, bruising, blistering, nausea, fainting, bleeding, infection and shock. I do not expect the acupuncturist to anticipate and explain all the risks and complications and I wish to rely on the acupuncturist to exercise judgment during the course of the procedure which the acupuncturist feels at the time, based upon the 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 content, and by signing below I agree to the above named procedures(s). I intend 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.

Dated this _____ day of _____, 20____

Name: (print) _____ (Signature) _____

Witness: (print) _____ (Signature) _____