CONFIDENTIAL PATIENT INFORMATION

Title: (please circle) Mr. Mrs. Ms Date of Birth: Day_____Month_____Year_____

Name: _____

Address: _____ Home Tel: _____

City: _____ Work Tel: _____

Postal Code: _____ Cell:_____

E-Mail:_____ **Are you a member of the ORC? YES NO**
(for appointment reminders)

Who or how were you referred to Club Physio Plus? _____

Primary complaint or body part injured and date of occurrence:_____

Was this injury due to a motor vehicle accident? (please circle one) YES NO

Family Doctor:_____ Specialist: _____

In case of emergency, who can we contact: Name:_____Tel # _____

PATIENT MEDICAL HISTORY

Surgical History (please list related surgeries first, than additional surgeries, incl. dates):

_____

Medications: (please list current prescription medication, incl. number, dose & frequency)

_____

_____

Previous Therapies: (circle one or more Physio, Athletic, A.R.T., Chiropractic, Acupuncture, Osteopathy, Dates & Reasons)

_____

Any other treatments received for this condition:_____

Do you have any history of the following medical conditions?

	Yes	No		Yes	No
Asthma	☐	☐	Gynecological Condition	☐	☐
Allergies	☐	☐	Are you pregnant?	☐	☐
Cardiac Problems	☐	☐	Streptococcal Infection	☐	☐
Hepatitis	☐	☐	Arthritis (family history)	☐	☐
Cardiac Pacemaker	☐	☐	Loss of Sensation	☐	☐
History of Headaches	☐	☐	Osteoporosis	☐	☐
Respiratory Problems	☐	☐	Metal Implants (screws, etc.)	☐	☐
Low/High Blood Pressure	☐	☐	Diabetes	☐	☐
History of Stroke	☐	☐	Infectious Skin Cond.	☐	☐
HIV/Aids	☐	☐	Epilepsy/Seizures	☐	☐
Hearing Problems	☐	☐	Vision Problems	☐	☐
Hernia	☐	☐	Cancer	☐	☐
Balance Problems	☐	☐	Concussions	☐	☐

CLUB PHYSIO PLUS CONSENT:

I understand that payment for services received at the clinic are my responsibility. If my claim is to be submitted directly to an outside agency for payment, and for some reason the third party payor, such as insurance company or employer, denies the claim and/or refuses to pay all or any of the full amount billed, I am responsible for paying the amount outstanding. For insurance purposes, I have been informed of my therapist's billing designation. I understand that the fees per visit for this service are:

FEES (Includes all applicable taxes)

Physiotherapy	Assessment	$110.00	Treatment (30min)	$75.00	(60min)	$150.00
Athletic Therapy	Assessment	$120.00	Treatment (30min)	$80.00	(60min)	$160.00
Acupuncture	Assessment	$110.00	Treatment (30min)	$75.00	(60min)	$150.00
Osteopathy	Assessment	$150.00	Treatment (30min)	$75.00	(60min)	$150.00
Chiropractic/ART	Assessment.	$120.00	Treatment (30min)	$85.00	(60min)	$170.00
Pedorthic	Assessment	$ 75.00				
**Massage	(30min)	$ 65.00	(60min)	$100.00	(90min)	$145.00
**Advanced Massage	(30min)	$ 75.00	(45min)	$ 95.00	(60min	$115.00

Massage is available at our Oakville location, for non ORC members only

For pricing of concussion assessment, testing and treatment, kindly contact our office.

Therapy treatment techniques may include, but are not limited to: manual techniques, electrotherapeutic modalities (e.g.: ultrasound, laser, microcurrent), and exercises as well as other techniques such as acupuncture and cupping. A number of these may be recommended during your treatment program. It is the policy of CLUB PHYSIO PLUS to ensure the benefits, side effects and potential complications of each chosen therapeutic techniques is explained to you by your therapist before use, as your participation in all aspects of the program is imperative to its success. Throughout your program, if you have any questions or concerns about any recommended treatment you must inform your therapist immediately so they can explain the treatment rationale and/or modify your program appropriately. If at any time you choose not to participate in the treatment program or any portion of it, you must inform your therapist immediately. I understand that for the duration of my treatment, my consent may be withdrawn at any time and understand that I must inform my therapist.

CANCELLATION/NO SHOW POLICY:

I agree to give Club Physio Plus **24 hours notice** in the event of a cancellation. If I do not give the required 24 hours notice, or fail to arrive for my scheduled appointment, I will be charged **50% of the regular rate**.

I understand and agree with the criteria above and as such agree to participate in an assessment and treatment program at CLUB PHYSIO PLUS.

Signed_____ Date_____

(If patient has a substitute decision maker, a guardian must sign for them)

Witness_____ Date_____

For patients seeing Russell Gunner, please initial below to acknowledge you understand that he is an Athletic Therapist and Acupuncturist and you will be billed under one of these licenses.

Initial:_____ _

CLUB PHYSIO PLUS
COVID-19 CONSENT FORM

Name: _____ **Date:** _____

Are you currently experiencing any of these symptoms? Choose any/all that apply	**Y**	**N**	**Are you currently experiencing any of these symptoms? Choose any/all that apply**	**Y**	**N**
Cough that's new or worsening (continuous, more than usual)			Fever (feeling hot to the touch, a temperature of 37.8 degrees Celsius or higher)		
Pink eye (conjunctivitis)			Headache (non-injury related)		
Runny nose (not related to seasonal allergies or other known causes or conditions)			Stuffy or congested nose (not related to seasonal allergies or other known causes or conditions)		
Shortness of breath (out of breath, unable to breathe deeply)			Digestive issues (nausea/vomiting, diarrhea)		
Extreme tiredness that is unusual (fatigue, lack of energy)			Lost sense of taste or smell		
Muscle aches			Difficulty swallowing		
Sore throat			Falling down often		
Barking cough, making a whistling noise when breathing (croup)			Chills		
Have you travelled outside of the country in the past 14 days?			Have you tested positive for the COVID 19 virus?		
Have you been in contact with anyone who has tested positive for the COVID 19 virus or experienced the symptoms above within the past 2 weeks?					

I hereby acknowledge that the above answers are true to the best of my knowledge. I acknowledge and accept that there is a risk that I could be exposed to COVID-19 while attending Club Physio Plus. I also acknowledge and accept that while receiving services, the therapist may need to be closer than the recommended social distancing guidelines in order to assess and/or treat me. I acknowledge and confirm that I am willing to accept this risk as a condition of attending at Club Physio Plus to receive services from the therapist. In consideration of the therapist agreeing to see me in person at Club Physio Plus, I agree to release the therapist and Club Physio Plus (if applicable), their officers, directors, employees, agents and volunteers (the “Releasees”) from any and all causes of action, claims, demands, requests, damages or any recourse whatsoever in respect of any personal injuries or other damages which may occur or arise as a result of exposure to COVID-19 during my visit to Club Physio Plus and/or through the provision of services to me by the therapist. I do hereby acknowledge and agree that notwithstanding the generality of the foregoing, I declare that I will not commence litigation or otherwise seek to recover damages or other compensation against the Releasees based on any action, claim, demand, request, loss or any recourse whatsoever arising from any potential or actual exposure to COVID-19 while attending at Club Physio Plus and/or through the provision of services to me by the therapist. I further acknowledge that the Releasees can rely on this Release of Liability, Waiver of all Possible Claims and Assumption of Risk as a complete defence to any and all claims, damages, causes of action, or recourse or liability that may arise at any time. I have carefully reviewed this Release of Liability, Waiver of all Possible Claims and Assumption of Risk and acknowledge that I fully understand the terms as set out above. I acknowledge that I am signing this Release of Liability, Waiver of all Possible Claims and Assumption of Risk voluntarily.

Signature _____