Mira Jindani
PHYSIOTHERAPIST

CSA PHYSIOTHERAPY

Physiotherapy Intake Form

Patient Information

Name		Home Phone	
Date of Birth		Work Phone	
Address		Cell Phone	
City			
Postal Code		AHC #	
Email address			

What is your primary purpose for attending today/what body region is bothering you?

_____

Occupation			
Family doctor		Doctor's phone #	
Emergency contact #		Relation	
How did you find us?			

Consent for Treatment

Physiotherapy treatment techniques may include, but are not limited to: manual techniques including spinal manipulation, electrotherapeutic modalities and exercise as well as other techniques such as acupuncture and intramuscular stimulation (IMS). A number of these may be recommended during your program. At any time your consent can be withdrawn. If you have any specific concerns regarding your sessions at Mira Jindani Physiotherapist, please discuss them with your therapist. By signing below I acknowledge I will be receiving an assessment and treatments for physiotherapy and accept the responsibility for the fees associated with these sessions.

_____ _____

Signature of patient (or guardian if patient under the age of 18) | Date

_____ _____

Signature of Witness | Date

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Billing and Office Policy

At Mira Jindani Physiotherapist, there is **no** physiotherapy coverage through *Alberta Health Services* (AHS). Physiotherapy treatment may be covered by either extended health insurance plans or motor vehicle accident insurance. Please let us know which method of payment will be used upon **first** assessment. Because benefit plans vary, please check the details of your coverage. It is the patient's responsibility to understand any limitations to coverage.

Agreement for Payment and Fees

I understand that payment for services received at the clinic is my responsibility. While coverage may be available at other clinics, there is *no* coverage for physiotherapy by the government (Alberta Health Services) through my services.

I understand that the fees per visit for this service are:

Initial assessment and treatment: $110
Follow up treatments: $85
Extended treatment/multiple body site $100

I understand the fees have been explained to me.

Signature _____

Late Cancellation and No Show Policy

In order to offer you quality service, we require **24 hours** notice of any changes to your appointment. This 24 hour notice allows us to offer your appointment to someone else on our waiting list. If you do not arrive for an appointment and do not call outside of 24 hours you will be charged for the full cost of the appointment. Your cooperation is greatly appreciated.

Signature _____
(if patient is under the age of 18, guardian must sign for them)

Witness _____

DIRECT BILLING POLICY

At Mira Jindani Physiotherapist we will do our best to provide direct billing for your services. It is the patient's responsibility to know their benefit plan and monitor the amount of coverage they have. In the event that coverage is denied or exhausted, the individual is responsible to pay any fees for services received.
I understand (initial): _____

Provider Name:_____Policy Number:_____Plan: _____

MOTOR VEHICLE ACCIDENTS (MVA):

Insurance Company:_____Policy #:_____Claim#: _____

Date of Accident: _____

*I understand that if my Motor Vehicle Accident Claim is **NOT** accepted, I am responsible for any payment/fees related to my treatments (initial):* _____

Health and Lifestyle Information

In order for your therapist to treat you in a safe manner, please provide us with the following information on your health and lifestyle. Do not worry about the questions that you are unsure of; your physiotherapist will go over them with you.

Are you pregnant? ☐ Yes ☐ No

Pregnancies and deliveries (number and year) _____

Do you have a pacemaker? ☐ Yes ☐ No

Name of other Healthcare Providers you are seeing for your problem:

_____

Have you ever suffered or do you currently suffer from the following conditions?

☐ Digestive problems	☐ Major traumas (accidents, falls)
☐ Headaches	☐ Osteoporosis
☐ Insomnia	☐ Inflammatory illness
☐ HIV/AIDS	☐ Major infections
☐ Neurological (i.e. Stroke, Seizures, Epilepsy)	☐ Diabetes
☐ Bladder Incontinence	☐ Respiratory problems/smoker
☐ Anxiety or Depression	☐ Cancer
☐ Orthopedic problems (including fractures and arthritis)	☐ Cardiac problems (high blood pressure, heart disease) or pacemaker
☐ Allergies	☐ Unexplained weight loss

List details for any checked above:

_____

_____

_____

Health and Lifestyle Information

List of ALL previous surgeries and the year they were performed:

List of ALL previous injuries (eg. Car accidents, falls, concussions, seizures, fractures etc).

List of all medication and supplements and reason for use.

What are your goals and expectations from physiotherapy treatment?

Please list anything else you feel would assist us in optimizing your experience and ensure your safety.

Consent to the Release of Medical Information

I,_____, give Mira Jindani Physiotherapist my informed consent to release/obtain information from the following individuals with respect to my care by report, letter, phone, fax, email or direct communication:

1. **Medical Professional(s):** to disclose medical information to and obtain medical information from my physician, specialists, or other treating therapists for the purpose(s) of assessing or providing treatment services

(Doctor Name):_____ Yes No _____Initials

_____ Yes No _____Initials

_____ Yes No _____Initials

2. **Employer or representative**: to discuss return to work information with employer or their representative (as discussed with physiotherapist)

(If applicable) _____ Yes No _____Initials

3. **Lawyer**: to disclose medical information to my lawyer

(*If applicable*)_____ Yes No _____Initials

5. **Other**

_____ Yes No _____Initials

I understand that my consent may be amended or revoked in whole or in part at any time by providing written notice to the Clinic, Mira Jindani Physiotherapist.

Client Name_____Signature _____ Date_____

FOR OFFICE USE ONLY: I am responsible for ensuring form is completed in full/witness signing & entering above information into the computer.

Name_____ **Signature**_____
Date_____

Freedom of Information and protection of privacy: All information provided to Mira Jindani Physiotherapist is collected under the Freedom of Information and Privacy Act in the Province of Alberta. This information is used to support your care. Your personal information will remain confidential. Thank you for your assistance.

Consent Form

Complete this section **BEFORE** seeing the therapist

Patient name:_____ Date:_____

Assessment
I understand and accept that to properly diagnose my condition, the therapist will interview me, will observe my movements and will perform a variety of tests, some of which may include palpation and other forms of physical contact. I understand that I may be required to disrobe and remove certain clothing. I may revoke my consent at any time without reason by informing the therapist.
I understand there is a $40 fee for appointments missed or cancelled with <24 hours notice. ☐

I intend this to be written consent for:
The release of x-ray reports and other diagnostic test reports or other pertinent information CSA Physiotherapy may require for the treatment of my condition including correspondence with other health care practitioners or individuals involved in my case. Yes ☐ No ☐ Initials _____

CSA Physiotherapy to release medical, treatment or other pertinent information requested by my insurance or benefit plan including Alberta Health Care. Yes ☐ No ☐ Initials _____

Complete this section **AFTER** seeing the therapist

Therapist name: _____

☐ My diagnosis was explained.

☐ The treatment was explained, including the possible risks and side effects. Therapist initials ☐

☐ I consent to the treatment, and understand that I can revoke my consent at any time. Patient initials ☐

The patient declines to consent to: _____

Potential Risks and Side Effects

Modalities (Ice, Heat, Ultrasound, Electrical Stimulation)
There is a small risk of skin burns with certain heating modalities. There is a small risk of infection if a treatment were to be applied over a skin wound. There is a small risk of electrolytic burn with certain types of electrical stimulation.

Acupuncture / Intramuscular Stimulation
All needles are single use, disposable and not shared between patients. Nevertheless, there is a small risk of infection when the needle goes into your body. There may be temporary soreness after the treatment, and there may be some bruising as well. There is also a small risk of having a brief fainting spell as a result of needle insertion. When certain points around the neck and back are treated, there is a very small risk of lung puncture. If this were to occur, you may notice difficulty breathing, and should go directly to the hospital for evaluation.

Exercise
There is a risk that exercises may make your muscles temporarily sore afterwards. If certain exercises are done improperly, there is a risk of further injury to your body. Your therapist will do their best to ensure that you perform the exercises most safely. For those with a compromised cardio-vascular system there is a risk of myocardial infarction (heart attack) during any cardiovascular exercise.

Spinal Manipulation
There is a small risk that you will temporarily have more soreness after a manipulation. There is a small risk that spinal manipulation will cause further injury to the spine. The therapist will do their best to provide the treatment in a way that minimizes this risk. There is also a very small association between certain manipulations of the neck and stroke causing coma and/or death. This is very rare and your therapist will not offer manipulation if they determine you are at risk for this.

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Consent to Communication Via Email

As per the *Privacy Information Act*, your consent is necessary to communicate with you via email. If you consent to communication via email, please complete this consent form and return it to us in person, by email or by fax (780-702-2019). We will file this consent form in your chart.

If you do not wish to consent to communication via email, please be advised we can no longer notify you of appointments, send receipts, updates, or clinic newsletters electronically and all further communication will need to be done in person or via telephone.

Thank you.

I,_____hereby consent to email communication with Mira Jindani Physiotherapist and "Physiomira" (Mira Jindani, physiotherapist) at my email address:

Email address:_____(or provided in chart).

As well, I am the email account holder and if other people have access to this account I give them consent to receive the information sent to this account.

Signed _____

Date _____

Freedom of Information and protection of privacy: All information provided to Mira Jindani Physiotherapist is collected under the Freedom of Information and Privacy Act in the Province of Alberta. This information is used to support your care. Your personal information will remain confidential. Thank you for your assistance.