BRUCE COUNTY CHIROPRACTIC & REHABILITATION CENTER

Pt#_____

NEW PATIENT INTAKE FORM

Date: _____

Name:_____

Address: _____ PO Box: _____

City: _____ Postal Code: _____

Home Phone #_____ Work# _____

Date of Birth (DD/MM/YYYY): _____ Age: _____Height:_____Weight:_____

What is your occupation? _____ Gender:_____

Emergency Contact:_____

Phone Number: _____ Relation: _____

Email Address for Appointment Reminders: _____

Preference for Email Reminders: 24 hours prior to appointment __ 48 hours prior to appointment __

Have you ever consulted a Chiropractor/ Physiotherapist previously? Y / N

If yes name:_____ Last visit date: _____

Have you ever consulted a personal trainer? Y / N

Medical Doctor's Name:_____ Last visit date: _____

What is your chief complaint: _____

When did you first notice the symptoms: _____

Any car accidents, falls, fractures?

Type of Injury_____ Date: _____

Type of Injury _____ Date: _____

Type of Injury _____ Date: _____

Previous Surgeries

Type of Surgery _____ Date: _____

Type of Surgery _____ Date: _____

Type of Surgery _____ Date: _____

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How did you hear about us? Please circle

Yellow pages, Radio advertisement, Friend or Relative, Other_____

Communication Consent

I give consent to BCCR to contact me through email for information relating to my treatments. This information includes but is not limited to rehabilitative programs, appointment notifications, unforeseen closures and or cancellations of my appointments. I also give consent to BCCR to leave a message on the phone number(s) listed below.

Patient's email address: _____

Primary phone number: _____
Please circle: cell home work

Secondary phone number: _____
Please circle: cell home work

No Show Policy

We value each of you as individuals and welcome the responsibility and privilege for supporting you as your health care professionals. Our goal is to treat each patient in a timely and efficient manner. With that as our focus we want to remind you of our clinic (in-person & virtual) policy concerning "no-show" appointments.

Failure to appear for your appointment without previously contacting the clinic will result in you being billed $20.00 for any chiropractic and physiotherapy scheduled appointments and 100% of the fee for any massage therapy appointments. We do have voicemail and email that we check regularly that a message may be left at.

Cancellation Policy

Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in the practitioner's day that could have been filled by another patient. As such, we require 24 hours notice for any cancellations or changes to your appointment. Patients who provide less than 24 hours notice, or miss their appointment, will be charged a cancellation fee of $20.00 for any chiropractic and physiotherapy appointments and 100% of the fee for any massage therapy appointments. Exception to this policy would include suddenly feeling unwell, developing a fever or any emergent event directly affecting the patient and or a family member. Please call the clinic and explain your situation to our staff if you have been unable to make your appointment due to unavoidable circumstances.

I am aware of and agree to the No Show Policy and Cancellation Policy.

_____ _____

Signature (Parent/Guardian if under 18 years of age) Date

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Consent to GBIN Online Medical Imaging Portal

If required I give my practitioner permission to access any medical imaging related to my treatment on GBIN Online Medical Imaging Portal

_____ _____

Signature (Parent/Guardian if under 18 years of age) Date

Consent to video or photograph(s)

As part of your assessment your practitioner may wish to take video or photograph(s). This source of media can assist your practitioner in further analyzing such things as posture, gait, exercise form or joint angles. If your practitioner feels that either of these sources of media would be beneficial to your assessment/treatment they will ask verbal permission from yourself during the session. Video and photo's are uploaded into your formal chart and removed from any other devices.

I am aware and agree to the video and photo consent

_____ _____

Signature (Parent/Guardian if under 18 years of age) Date

Privacy and Sharing of Information

I authorize Bruce County Chiropractic and Rehabilitation Center and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

_____ _____

Signature (Parent/Guardian if under 18 years of age) Date

Consent to Charges Incurred

I agree and understand that I am responsible for all charges relating to my visit

_____ _____

Signature (Parent/Guardian if under 18 years of age) Date

Please note:

All accounts are the responsibility of the patient. Your supplemental or extended health care insurance plan may provide coverage for Chiropractic/ Physiotherapy / Registered Massage / Naturopathic services. We will issue a receipt for each payment for this purpose.

Our fees for service are listed on our front desk. Please ask any questions you have regarding our service fees.