PATIENT INTAKE SHEET

PATIENT INFORMATION
Name:
Date of Birth: **mm/dd/yyyy**
Home Phone #:
Work Phone #:
Home Address: **Postal Code:**
Email Address: Would you like appointment notifications by email? ☐ Yes ☐ No   *Your email is never shared or rented.
Health Card #:
Emerg. Contact Name: **Relationship:**
Emerg.Contact Phone #:
Previously attended TruHealth: Yes/No   **Year 19 __ or 20__**

REFFERAL INFORMATION
How did you hear about TruHealth?
Family Physician: **Referring Physician:**
Did you stay in the hospital overnight for your injury? Yes or No   **Which Hospital?**

WORKPLACE INJURY (WSIB)
Date of Injury:
Claim #:
Name of Employer:
Employer Contact Address & Phone #:

MOTOR VEHICLE ACCIDENT
Date of Accident:
Insurance Company:
Adjuster's Name:
Adjuster's Phone #:
Adjuster's Fax #:
Adjuster's Address:
Policy / Claim #:
Previous treatment for injuries sustained: **Yes / No**
Completed Accident Benefits Package: **Yes / No**

EXTENDED HEALTH INSURANCE
Primary Insurance Company:
Plan /Group /Policy/Contract#:
ID/Certificate/Perm #:
Name of Policy Holder:
Date of Birth of Policy Holder:
Name of Employer:
Secondary Insurance Company:
Plan/Group/Policy/Contract#:
ID/Certificate/Perm#:
Name of Insured:
Date of Birth of Insured:
Name of Employer:

CONFIDENTIAL MEDICAL SCREENING QUESTIONNAIRE

Name: ____________________ **Date of Birth**: mm / dd / yy

1. Do you presently or have you ever suffered from any of the following? *(Check all that apply)*

- ❑ Heart problems
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Stroke
- ❑ Lung problems
- ❑ Cancer
- ❑ Diabetes
- ❑ Osteoporosis
- ❑ Broken bones / fractures
- ❑ Hepatitis
- ❑ Arthritis (eg. rheumatoid)
- ❑ HIV / AIDS
- ❑ Kidney problems
- ❑ Repeated infections
- ❑ Thyroid problems
- ❑ Skin disease or sensitivity
- ❑ Depression
- ❑ Asthma
- ❑ Epilepsy / Seizures

Allergies: ____

2. Have you had any surgeries or major dental work? *(Please list)*

____________________________________ ____________________________________
____________________________________ ____________________________________

3. Please provide a list of your current medications:

_______________________ _______________________ _______________________
_______________________ _______________________ _______________________

4. Do you have a pacemaker? ❑ Yes ❑ No

5. Do you smoke? ❑ Yes *(_____ pack(s)/day)* ❑ No

6. Do you feel that you currently have significant stress in your life? ❑ Yes ❑ No

7. FOR WOMEN: Are you currently pregnant or think you may be pregnant? ❑ Yes ❑ No

8. I am **optimistic** that my present problem will improve. *(Please circle one)*

1	2	3	4	5
Strongly disagree	Disagree	No opinion	Agree	Strongly Agree

Signature: ___________________________ **Date**: mm / dd / yy

OFFICE POLICIES AND PROCEDURES

In our effort to provide the highest quality of care to each of our patients, we have compiled our office policies for you.

APPOINTMENTS:

- Please be on time, sign in for each of your appointments and bring your appointment card
- Please book your appointments by the end of each week for the next week
- Cancel your appointment if you are unable to attend, if you miss several appointments without reason, we may have to notify your physician or insurance company and you may be discharged
- Patients may be charged $25.00 for all missed appointments

SAFETY:

- Please wear clothing that is appropriate for exercise
- Children must be under adult supervision and are not to play with any equipment
- Please notify your treating therapist of any change in your condition or anything you are unsure about
- Please call for assistance immediately if you are in any discomfort during your treatment
- If you have inhalers or nitro spray, please have it with you at all times while in the clinic

WORKERS SAFETY AND INSURANCE BOARD (WSIB):

- If you are attending treatment as a result of a work injury, you must report your injury to the appropriate agencies.
- You are responsible for providing our office with your claim number as soon as it is issued.
- **Please be aware that if your claim through WSIB is denied, you are responsible for any and all charges accrued for your treatment at our facility**.

MOTOR VEHICLE ACCIDENT (MVA):

- A physicians referral is recommended
- You must submit your Accident Benefits Package to your insurance company within 30 days of receipt
- Please provide our office with all of your relevant information (insurance company, claim number etc.) so that we can process your claim
- **We are required by law to bill any extended health plan you have before billing your car insurance company**
- Please be aware that you are responsible for forwarding to our office all payments made to you by the insurance company for treatment received at our facility.
- If payment is not forwarded once it is obtained from your insurance carrier, we reserve the right to take appropriate action to recover the charges accrued for your treatment.

EXTENDED HEALTH CARRIER BILLING:

- You will need to provide us with your policy and ID number if you would like us to help you check your coverage.
- For direct billing, you assign the above clinic the benefits to which you are entitled for this claim
- Please be aware that you are responsible for forwarding all payments made to you by the insurance company to our office for treatment received at our facility. Please let us know if you experience delays with your insurance company
- If payment is not forwarded once it is obtained from your insurance carrier, we reserve the right to take appropriate action to recover the charges accrued for your treatment.

PRIVATE PAYMENT:

- A physicians referral is NOT required
- Physiotherapy assessment fee is $70, the subsequent treatment fee is $50
- Reduced rates may be applied at the discretion of your therapist

I have read and understand the above policies and procedures. I consent to the collection, use and disclosure of my personal information. The purpose of this collection is to provide assessment and treatment services relevant to my needs and to obtain information related to payment for the services provided. The information collected may be disclosed to my referring physician or funding agency and discussed among my treatment team.

Signature: ____ **Date:** ____________________