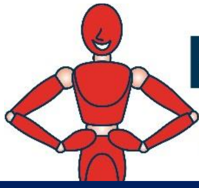


Registration and Consent

t: (519) 455-4030
f: (519) 455-6225

Section 1: Patient Information

Title	First Name	Middle Name	Last Name

Gender	Address (no., street, apt, RR)			
☐ Male	City/Town	Prov.	Postal Code	Date of Birth
☐ Female	Home Phone	Work Phone		Other Phone
☐ Other	E-mail	May we send you appointment reminders by E-mail? ☐YES May we send you other information by E-mail? ☐YES		

How did you hear about us?

Section 2: Emergency Contact/Guardian Information

First Name	Last name
Phone	Relationship

Section 3: Auto Insurance Claim Information

Auto Insurance Company		Date of Collision	
Auto Insurance Adjuster	Adjuster Phone	Claim Number	
Extended Health Care Company	Group Number	ID Number	☐ I'm not covered by any extended health care plan

Section 4: WSIB Claim Information

Employer		Date of Injury
Supervisor Name		Claim Number
Job Title	Area of Injury	Social Insurance Number

Section 5: Consent to Disclosure of Medical Information

I hereby authorize Body Mechanics to release and/or obtain written and/or verbal medical information regarding my assessment, progress, discharge and other factors relating to my treatment to/from the following.

Doctor/Specialist	Hospital	Other

I understand the purpose for disclosing this personal health information to the person/facility noted above.
I understand that I can refuse to provide consent by leaving the above spaces blank.

Section 6: Payment Agreement and Signatures

By signing below I agree to the following:
I understand that the services that I am seeking at Body Mechanics to are **not covered by the Ontario Health Insurance Plan (OHIP)**. Also, I will be fully responsible for all costs incurred in my treatment should my third party sponsor (WSIB, Auto Insurance, Extended Health Care, etc…) deny my claim.
I consent to participating in today's assessment. I understand that my consent is completely voluntary, and that consenting to services provided by Body Mechanics is an ongoing process. I have the right to withdraw my consent at any time by informing the treating therapist or a staff member.

Patient <u>OR</u> Patient/Guardian Signature	Date	Witness Signature	Date

Privacy Policy

t: (519) 455-4030
f: (519) 455-6225

Name: ____________________________ Date of Birth: ______________ Date: _______________

Privacy of personal information is an important principle to the Body Mechanics. We are committed to collecting, using and disclosing personal information responsibly and only to the extent necessary for the goods and services we provide. We also try to be open and transparent as to how we handle personal information. This document briefly describes our privacy policies. To view our complete privacy policy, please consult the privacy officer listed below or your treating therapist.

What Is Personal Information?
Personal information is information about an identifiable individual. Personal information includes information that relates to their personal characteristics (e.g., gender, age, home address or phone number, etc…) and their health (e.g., health history, health conditions, health services received by them.)

Who We Are
Our organization, includes Physiotherapists and Administrative support staff. We may at times use consultants and agencies that may, in the course of their duties, have limited access to personal information we hold. These include computer consultants, office security and maintenance, bookkeepers and accountants, temporary workers to cover holidays, credit card companies, cleaners and lawyers. We restrict their access to any personal information we hold as much as is reasonably possible. We also have their assurance that they follow appropriate privacy principles.

We Collect Personal Information
Like all medical professionals, we collect, use and disclose personal information in order to serve our clients and to provide appropriate clinical care. It would be rare for us to collect such information without the client's express consent, but this might occur in an emergency (e.g., the client is unconscious) .

Like most organizations, we also collect, use and disclose information for secondary purposes. The most common examples are as follows:

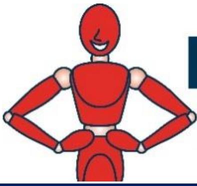
- To perform standard chart audits ensuring that we provide high quality services, including assessing the performance of our staff.
- Physiotherapists are regulated by the College of Physiotherapists of Ontario who may inspect our records and interview our staff as a part of their regulatory activities in the public interest.
- Like all organizations, various government agencies (e.g., Canada Customs and Revenue Agency, Information and Privacy Commissioner, Human Rights Commission, etc.) have the authority to review our files and interview our staff as a part of their mandates. In these circumstances, we may consult with professionals (e.g., lawyers, accountants) who will investigate the matter and report back to us.
- To invoice clients for goods or services that were not paid for at the time, to process credit card payments or to collect unpaid accounts.
- The cost of some goods/services provided by the organization to clients is paid for by third parties (e.g., OHIP, WSIB, private insurance, Assistive Devices Program). These third-party payers often have your consent or legislative authority to direct us to collect and disclose to them certain information in order to demonstrate client entitlement to this funding.
- We retain our client information for a minimum of ten years after the last contact to enable us to respond to those questions and provide these services (our regulatory College also requires us to retain our client records).

Do You Have a Question?

Our Information Officer, Brian Harris, can be reached at:
Fitness Forum
900 Jalna Blvd.
London, ON N6E 3A4
PHONE (519) 681-1228

Please sign below to indicate that you have read and understand the above information regarding our privacy policy.

______________________	__________	______________________	__________
Signature	Date	Witness Signature	Date

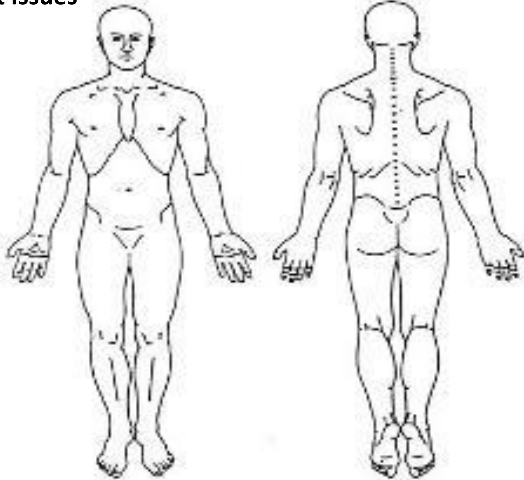


Health Status Survey

t: (519) 455-4030
f: (519) 455-6225

Name: ______________________________ **Date of Birth:** _______________ **Date:** ________________

Current Issues



Please shade in your current area(s) of pain or primary concern

Work:
Currently working? ☐ Yes ☐ No
Regular occupation: ______________________________
Regular hours / duties? ☐ Yes ☐ No

Home:
Are you performing your regular housekeeping duties?
☐ Yes ☐ No

Personal care:
Are you able to fully care for yourself? (dress, bathe, etc.)
☐ Yes ☐ No

Recreation:
Are you participating in your normal recreation activities?
☐ Yes ☐ No
Regular recreation activities: _______________________
____

Health Status – please indicate if you currently have, or have had any of the following conditions in the past

Infections:	current	past
• MRSA, VRE, C-Diff	☐	☐

General Health:	current	past
• Metal implants	☐	☐
• **Total joint replacements**	☐	☐
• Fractures/bone breaks	☐	☐
• Dizziness	☐	☐
• Slurred speech	☐	☐
• Difficulty swallowing	☐	☐
• Double vision	☐	☐
• Sudden fainting	☐	☐
• Loss bowel/bladder control	☐	☐
• Sensation changes	☐	☐
• Loss of sensation in the genital region	☐	☐
• **Cancer**	☐	☐
• Unexplained weight loss	☐	☐
• Significant night pain	☐	☐
• Fever/chills	☐	☐
• Night sweats	☐	☐
• **Osteopenia/Osteoporosis**	☐	☐

Other: ________________________

Digestive System:	current	past
• Colitis/IBS	☐	☐
• Nausea/Vomiting	☐	☐
• GERD/heart burn	☐	☐
• Blood in stool	☐	☐
• Ulcers	☐	☐

Other: ________________________

Medications:	current	past
• Blood thinners *(Cumadin/Warfrin/Heparin/high dose Aspirin)*	☐	☐
• Cortico-steroids *(Prednisone)*	☐	☐
• Antidepressants	☐	☐

• Other: ________________________
____

Ears, nose, throat:	current	past
• Hearing loss	☐	☐
• Ringing in ears	☐	☐
• Smell /taste issues	☐	☐
• Hoarseness	☐	☐
• Speech difficulty	☐	☐

• Other: ________________________

Respiratory system:	current	past
• Pain with cough/sneeze	☐	☐
• Chronic cough	☐	☐
• Coughing up blood	☐	☐
• Shortness of breath	☐	☐
• Asthma	☐	☐

• Other: ________________________

Genitourinary system:	current	past
• Bladder infection	☐	☐
• Bladder function change (Frequency/Incontinence/Retention)	☐	☐
• Blood in urine	☐	☐
• Change in sexual function	☐	☐

• Other: ________________________

Nervous system:	current	past
• Epilepsy /seizures	☐	☐
• Stroke	☐	☐

• Other: ________________________

Cardiovascular system:	current	past
• Bleeding disorder	☐	☐
• High/low blood pressure	☐	☐
• High blood cholesterol	☐	☐
• Heart attack	☐	☐
• Chest pain/discomfort	☐	☐
• Irregular heart beat	☐	☐
• Pacemaker	☐	☐
• Leg/ankle swelling	☐	☐

• Other: ________________________

Endocrine system:	current	past
• Diabetes	☐	☐
• Thyroid problems	☐	☐

• Other: ________________________

Skin:	current	past
• Wounds/lesions/rashes	☐	☐
• Psoriasis	☐	☐
• Sensitive skin	☐	☐

Women's Health:	yes	no
• Are you pregnant	☐	☐

how many weeks? ________

Other: ________________________

I have none of the above and am in good health! ☐

____
Signature