CLEARWATER PHYSICAL THERAPY – Massage Therapy

PATIENT INFORMATION

First Name:	**Last Name:**	**DOB:** _____ day mon yr
Address:	**City:**	**Province:**
Postal Code:	**Home Phone #:**	**Cell Phone #:**
Work Cell #:	**Email:**	**Future Appointment Reminders?** □ Phone □ Text
Occupation/Employer:	**Alberta Health Care Number:**	
Physician Name:	**Physician Phone #:**	**Type of Injury:** **(Body part)**
Workers' Compensation Injury? □ No **Date:**_____ □ Yes	**Recent Motor Vehicle Accident?** □ No **Date:** _____ □ Yes	**Are you on Disability?** □ Yes □ No

Emergency Name: **(Relationship):**	**Phone Number:**	**Have you received therapy before?** □ **No** □ **Yes** **Where?** _____

Why are you here?

PATIENT RESPONSIBILITY – *Please read the following carefully*

You are seeing an MASSAGE Therapist at Clearwater Physical Therapy:

- WE cannot guarantee your insurance information is up to date and/or accurate as coverage may have been used, terminated or changed between treatments
- Patient Insurance Policies are all different – it is your responsibility to stay informed about your policy and check if you have coverage for this service
- You are responsible for all debts that are incurred

Cancellations:

- You will be charge 50% of your appointment fee if you fail to attend or cancel within 12 hours' notice as CWPT has supplied time, staffing and resources for your appointment.

Fees:

- All fees are due at the time of service. If we are direct billing through insurance for you, a credit card number, expiry date and signature are needed on file. This authorizes us to take payment if your account is outstanding and/or any unpaid balances not covered by your insurance.
- If you refuse to leave your credit card then you will be responsible for paying for your services upfront and submit it to your insurance company directly.
- Your insurance is a contract between you, the employer and the insurer not CWPT. Our staff will help facilitate paperwork on your behalf. Any questions about insurance coverage must be directed to your insurer.

I agree to leave a VISA or MC on File: #_____ - _____ - _____ - _____ Exp ___/___

Name of Insurance:	**Name of Insured:**	
Group Number:	**Policy Number:**	**Birthday of Insured:**
Coverage Percentage: ***(example: 80% per treatment)***	**Amount of Coverage per day:** ***(example: $50.00 per day)***	**Total amount of annual coverage:** ***(example: $500 per day)***
Deductible: □ No □ Yes **Amount:**	**Coverage Start Date:**	**Coverage End Date:**

I have read and understood this entire document:

Signature: **Date:** **Staff Initial:**

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Patient Medical Information

Have you EVER been diagnosed with any of the following conditions? (check all that apply)

□ Cancer	□ Heart Disease	□ High Blood Pressure	□ Osteoporosis	□ Pacemaker inserted
□ Asthma	□ Stroke	□ Depression	□ Diabetes	□ Anemia/other blood diseases
□ Smoking	□ Lung Disease	□ Multiple Sclerosis	□ Seizures	□ Rheumatoid Arthritis
□ Thyroid Problems	□ Stomach Ulcers	□ Epilepsy	□ Parkinson's Disease	□ Kidney/Liver Problems
□ Any Electrical Inserts	□ Steroid Use or addiction	□ TMJ	□ Skin Conditions	□ Headaches/Migraines
□ Whiplash	□ Surgery	□ Fainting/Dizziness	□ Circulation Conditions	□ Hepatitis/HIV
□ Varicose Veins	□ Irritation Eyes/Ears	□ Pain in Abdomen/Chest	□Arm/Leg Pain	□ Lower Back Pain
□ Fractures	□ Motor Vehicle Accident			

Have you RECENTLY noted any of the following? (check all that apply)

□ Nausea/vomiting	□ Weight loss/gain	□ Fever/chills/sweats	□ Headaches	□ Changes in bowel/bladder function
□ Shortness of breath	□ Change in Appetite	□ Weakness/fatigue	□ Pain at Night	□ Dizziness/light headedness
□ Difficulty swallowing	□ Whiplash	□ Difficulty maintaining balance while walking		

Please describe your present symptoms as best you can (when, where, how and what does it feel like):

_____

_____

Does this condition interfere with your daily life? If yes, please explain:

_____

_____

Are you CURRENTLY Pregnant?(for women) □ NO □ YES **Due Date:** _____

Are you CURRENTLY taking any medications or supplements? (Please list them below)

_____

_____

I, _____, acknowledge the all the information I have given is true and accurate._____ (Initial).

FOR THERAPIST ONLY:

Other Comments:

_____

_____

_____

INFORMED CONSENT FOR TREATMENT:

I, _____(PRINT NAME), hereby authorize the registered massage therapist to perform upon me: an initial massage therapy assessment and a massage therapy treatment. I am aware that this will require manual, hands on treatment. I have been informed of the possible risks, adverse reactions and benefits of receiving this service. I also authorize CWPT to contact my physician regarding my assessment and treatment updates as needed. This has been explained to me in a language that I understand and the therapist has been a witness to my consent.

_____ _____

Patient's Signature ***Date***

I, _____(PRINT NAME), do herby certify that I have explained all the features, benefits and complications of the initial assessment and treatment and have fully satisfied all his/hers questions.

_____ _____

Therapist Signature ***Date***