Patient Information

Date:

First Name:		Surname:	
Address: City:		Postal Code:	
Home Phone#:	Mobile #:	Email Address:	
Sex: M_____ F____		Date of Birth (mm/dd/yyyy): / /	
Name of Emergency Contact:	Relationship:	Home Phone: ( )	Work Phone: ( )

Employer Information

Name of Employer:	
Address: City:	Postal Code:
Business Phone#:	
Occupation:	

Insurance Information

Do you have Private Insurance?	Yes ☐	No ☐
If yes please fill in the following section. Consent to check for Insurance Coverage?	Yes ☐	No ☐
Insurance Name:		
Address:		
Phone #	Fax #	
Policy #	Group #	
ID. #	Plan #	
If you are covered under someone else please fill in the following: Name of Insured:	DOB of Insured (mm/dd/yyyy): / /	

Referring Physician Information

Doctors Name:	
Address:	
Phone #	Fax #

Refusal to Disclose Insurance Information

I, ______________________, do not wish to disclose my extended health care benefits insurance information to Novo Healthnet Limited.

I am aware that the reason for this request is to keep track of my coverage and agree that I will personally keep track and be responsible for my account.

______________________	______________________
(Patient Signature)	(Administrator Signature)
______________________	______________________
(Date)	(Date)

Novo Healthnet Limited
Retirement Home Division

PHYSIOTHERAPIST, REHABILITATION and MASSAGE THERAPIST INFORMED CONSENT

As a matter of ethics and law there is an obligation, prior to examination and treatment, to disclose any material risk to the patient in order to obtain a valid informed consent. As part of the physiotherapy, chiropractic and massage treatments, certain procedures and devices may be utilized such as the use of heat, ice, electrotherapy, ultrasound, massage and manual therapy. As part of the rehabilitation program (kinesiologist, occupational therapist or physical therapist assistant) certain testing procedures, devices and equipment may be utilized such as weight machines, exercise, cardiovascular work and functional tasks. I have had the opportunity to discuss with the doctor of chiropractic/physiotherapist and/or other clinical staff, the nature and purpose of treatments. I understand the results are not guaranteed. I further understand and I am informed that there are some very slight risks to treatments, including, but not limited to, muscle strains, sprains, disc injuries, and burns have been made aware that there are remote chances of injury and that appropriate tests will be performed to help identify if I may be susceptible to risk or injury

DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE PHYSIOTHERAPIST

I hereby acknowledge that I have discussed with the physiotherapist the assessment of my condition and the treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I hereby consent to p treatment as proposed to me.

Patient Signature: ________________________________ Date:_______________________

Parent/Guardian Signature: __________________________ Date:_______________________

Witness Signature: _______________________________ Date:_______________________

CONSENT TO CHIROPRACTIC TREATMENT

It is important for you to consider the benefits, risks and alternatives to the treatment options offered by your chiropractor and to make an informed decision about proceeding with treatment.
Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body, soft-tissue techniques such as massage, and other forms of therapy including, but not limited to, electrical or light therapy and exercise.

Benefits

Chiropractic treatment has been demonstrated to be effective for complaints of the neck, back and other areas of the body caused by nerves, muscles, joints and related tissues. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility, improve function, and reduce or eliminate the need for drugs or surgery.

Risks

The risks associated with chiropractic treatment vary according to each patient's condition as well as the location and type of treatment.
The risks include:

- **Temporary worsening of symptoms** – Usually, any increase in pre-existing symptoms of pain or stiffness will last only a few hours to a few days.
- **Skin irritation or burn** – Skin irritation or a burn may occur in association with the use of some types of electrical or light therapy. Skin irritation should resolve quickly. A burn may leave a permanent scar.
- **Sprain or strain** – Typically, a muscle or ligament sprain or strain will resolve itself within a few days or weeks with some rest, protection of the area affected and other minor care.
- **Rib fracture** – While a rib fracture is painful and can limit your activity for a period of time, it will generally heal on its own over a period of several weeks without further treatment or surgical intervention.
- **Injury or aggravation of a disc** – Over the course of a lifetime, spinal discs may degenerate or become damaged. A disc can degenerate with aging, while disc damage can occur with common daily activities such as bending or lifting. Patients who already have a degenerated or damaged disc may or may not have symptoms. They may not know they have a problem with a disc. They also may not know their disc condition is worsening because they only experience back or neck problems once in a while.

Chiropractic treatment should not damage a disc that is not already degenerated or damaged, but if there is a pre-existing disc condition, chiropractic treatment, like many common daily activities, may aggravate the disc condition.
The consequences of disc injury or aggravating a pre-existing disc condition will vary with each patient. In the most severe cases, patient symptoms may include impaired back or neck mobility, radiating pain and numbness into the legs or arms, impaired bowel or bladder function, or impaired leg or arm function. Surgery may be needed.

- **Stroke** – Blood flows to the brain through two sets of arteries passing through the neck. These arteries may become weakened and damaged, either over time through aging or disease, or as a result of injury. A blood clot may form in a damaged artery. All or part of the clot may break off and travel up the artery to the brain where it can interrupt blood flow and cause a stroke.

Many common activities of daily living involving ordinary neck movements have been associated with stroke resulting from damage to an atery in the neck, or a clot that already existed in the artery breaking off and travelling up to the brain.

Chiropractic treatment has also been associated with stroke. However, that association occurs very infrequently, and may be explained because an artery was already damaged and the patient was progressing toward a stroke when the patient consulted the chiropractor. Present medical and scientific evidence does not establish that chiropractic treatment causes either damage to an artery or stroke.
The consequences of a stroke can be very serious, including significant impairment of vision, speech, balance and brain function, as well as paralysis or death.

Alternatives

Alternatives to chiropractic treatment may include consulting other health professionals. Your chiropractor may also prescribe rest without treatment, or exercise with or without treatment.

Questions or Concerns

You are encouraged to ask questions at any time regarding your assessment and treatment. Bring any concerns you have to the chiropractor's attention. If you are not comfortable, you may stop treatment at any time.

Please be involved in and responsible for your care. Inform your chiropractor immediately of any change in your condition.

DO NOT SIGN THIS FORM UNTIL YOU MEETWITH THE CHIROPRACTOR

I hereby acknowledge that I have discussed with the chiropractor the assessment of my condition and the treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I hereby consent to chiropractic treatment as proposed to me.

Patient Signature: ________________________________ Date:______________________

Parent/Guardian Signature: __________________________ Date:______________________

Witness Signature: _______________________________ Date:______________________

CONSENT AND AUTHORIZATION FOR RELEASE/LOAN OF MEDICAL INFORMATION/DIAGNOSTIC MATERIAL

Patient Name : ________________________

Policy/Claim No. : ________________________

File No. : ________________________

D.O.L. : ________________________

I,_________________________ do hereby give my written permission and authorization to Novo Healthnet Limited to communicate on my behalf, release and share information regarding my health and progress, for the purpose of determining my functional abilities for developing and implementing a functional rehabilitation program.

I give permission to the following to provide and receive information pertaining to my medical condition.

Family Physician : ___________________________

Insurance Company : ___________________________

Employer : ___________________________

Rehab Consultant : ___________________________

Lawyer : ___________________________

Other : ___________________________

This consent may be revoked in writing at any time. Any such revocation shall have no effect on disclosures made prior to the date of revocation is received. I UNDERSTAND THAT I HAVE THE RIGHT TO INSPECT AND COPY THE INFORMATION TO BE DISCLOSED.

Patient Signature: ___________________________________ Date:_________________________

Parent/Guardian Signature: ___________________________________ Date:______________________ ______

Witness Signature: __________________________________ Date:_________________________

NOVO
HEALTHNET

PHYSICAL ACTIVITY READINESS QUESTIONNAIRE (PAR-Q)

Name: ____

For most people physical activity should not pose any problem or hazard. The Par-Q has been designed to identify the small number of adults for whom physical activity might be inappropriate for or for those who should have a medical concern regarding the type of activity most suited to their needs.

Common sense is your best guide in answering the following questions. Please read them carefully and check Yes or No for each question. If you checked Yes and feel the need to elaborate please use the designated space below the question to give additional details.

1. Has a doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor? Yes ☐ No ☐
2. Do you feel pain in your chest when you do any physical activity? Yes ☐ No ☐
3. In the past month have you had any chest pain when you were not performing any physical activity? Yes ☐ No ☐
4. Do you lose your balance because of dizziness or have you ever lost consciousness? Yes ☐ No ☐
5. Do you have a bone or joint problem that could be made worse by a change in your physical activity? Yes ☐ No ☐
6. Is your Doctor currently prescribing drugs (ex: water pills) for your heart condition or any high blood pressure? Yes ☐ No ☐
7. Do you know of any other reason why you should not do any physical activity? Yes ☐ No ☐
8. Do you currently participate in any regular activity/program designed to improve or maintain your physical fitness? If yes, please indicate what type of program or activity. Yes ☐ No ☐

   ____

   ____

9. If you suffer a cardiac arrest or rendered unconscious in our facility, would you consent for a certified CPR Clinician to perform emergency procedures? Yes ☐ No ☐

Please indicate any of the following conditions you have:

	YES	NO		YES	NO
Arthritis	☐	☐	Hernia	☐	☐
Diabetes	☐	☐	Depression	☐	☐
Thyroid Condition	☐	☐	Osteoporosis	☐	☐
Dizziness/Fainting	☐	☐	Smoking History	☐	☐
Low/High Blood Pressure	☐	☐	Reynaud	☐	☐
Heart Condition	☐	☐	Sleeping Problems	☐	☐
Chest Pain	☐	☐	Cough	☐	☐
Pacemaker	☐	☐	Vision Difficulties	☐	☐
History of Cancer	☐	☐	Swallowing Difficulties	☐	☐
Allergies to Tape/Latex	☐	☐	Slurred Speech	☐	☐
Any Allergies	☐	☐	Memory Problems	☐	☐
Epilepsy/Seizures	☐	☐	Balance Problems	☐	☐
Shortness of Breath	☐	☐	Recent Falls/Blackouts	☐	☐
Asthma	☐	☐	Unexplained Weight Loss/Gain	☐	☐
Bronchitis	☐	☐	Groin Numbness/Tingling	☐	☐
Other Respiratory Condition	☐	☐	Bowel & Bladder Difficulties	☐	☐
Hearing Impairment	☐	☐	Headaches	☐	☐
Pregnancy	☐	☐	Blood Diseases	☐	☐
Metal Implants (Incl IUD)	☐	☐	Other: ________________________	☐	☐

SURGERIES: (please list) ____

PREVIOUS INJURIES: ____

DATES: ____

INJECTIONS: (please list) ____

DATES: ____

TREATMENT FEES

INITIAL ASSESSMENT FEE (PHYSIO/CHIRO) SUBSEQUENT SESSIONS	$______________________ $______________________
MASSAGE THERAPY 1HR SESSIONS MASSAGE THERAPY 30 MIN SESSIONS	$______________________ $______________________
INITIAL ASSESSMENT FEE (ACUPUNCTURE) SUBSEQUENT SESSIONS $	$______________________ $______________________

I, ___________________________, AGREE TO THE FEES ABOVE AND ALSO AGREE THAT ANY REMAINING BALANCE WILL BE PAYABLE BY MYSELF.

______________________________ ______________________________

PATIENT SIGNATURE DATE

______________________________ ______________________________

WITNESS SIGNATURE DATE

NOTIFICATION FOR EXTENDED HEALTH COVERAGE

PHYSIOTHERAPY COVERAGE

Maximum coverage per calendar year: ______________________
Maximum cost per treatment: ______________________
Amount Remaining: ______________________

MASSAGE COVERAGE

Maximum coverage per calendar year: ______________________
Maximum cost per treatment: ______________________
Amount Remaining: ______________________

CHIROPRACTIC COVERAGE

Maximum coverage per calendar year: ______________________
Maximum cost per treatment: ______________________
Amount Remaining: ______________________

ORTHOTICS COVERAGE

Maximum coverage per calendar year: ______________________
Maximum cost per treatment: ______________________
Amount Remaining: ______________________
Who can dispense (DC or PT): ______________________

NATUROPATHIC/DIETICIAN COVERAGE

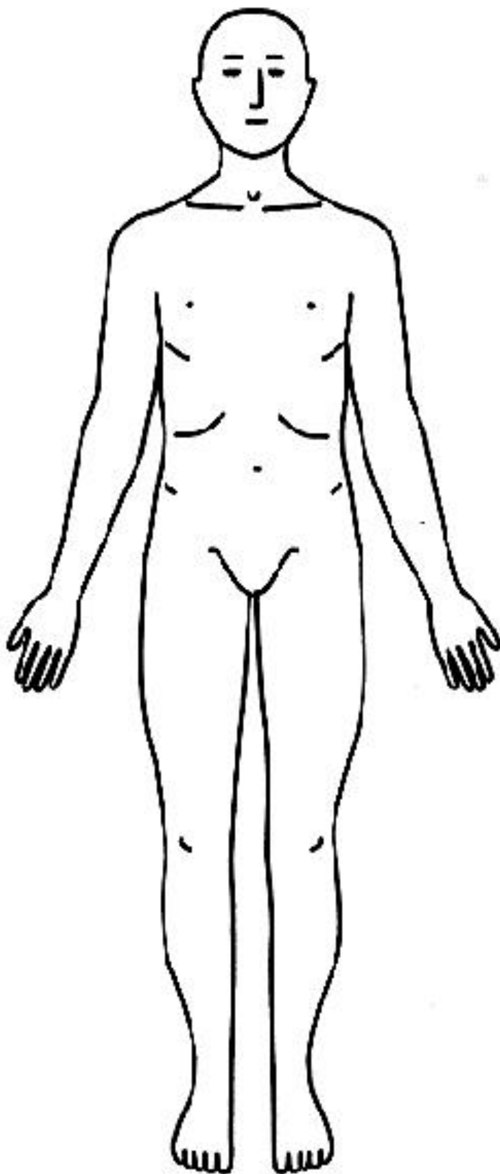
Maximum coverage per calendar year: ______________________
Maximum cost per treatment: ______________________
Amount Remaining: ______________________

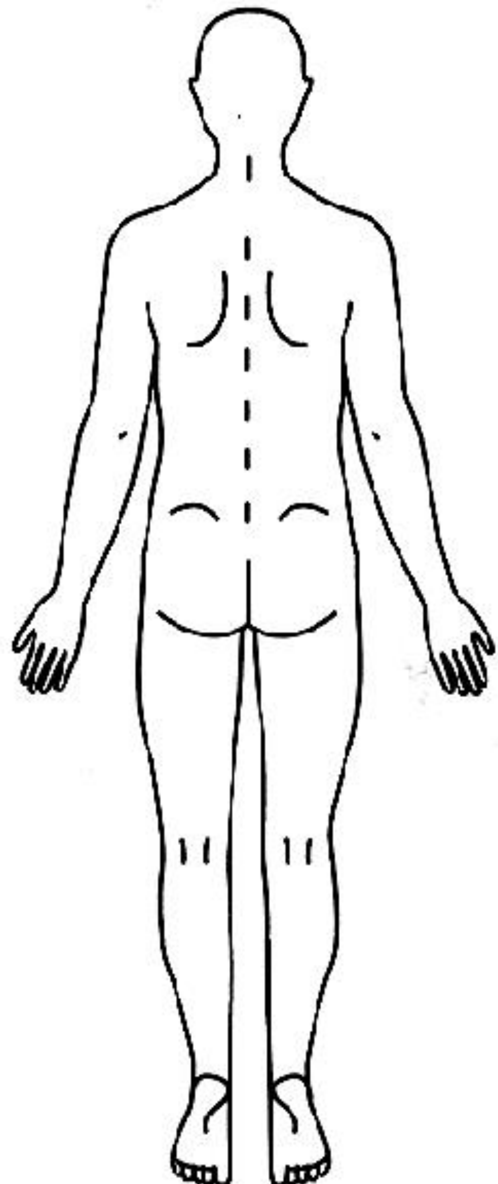
ACUPUNCTURE COVERAGE

Maximum coverage per calendar year: ______________________
Maximum cost per treatment: ______________________
Amount Remaining: ______________________

Achy or Constant Pain	XXX
Sharp Pain	****
Stiffness	////
Numbness	ooo
Other	____

Mark the area on the picture below with the appropriate symbol to best illustrate your symptoms.





PATIENT REHABILITATION CONTRACT

In order to ensure comprehensive and quality care, we believe that it is important that doctors, therapists and patients work together. The staff at Novo Healthnet Limited are committed to making your recovery a positive experience and we require the same commitment from you, our patient.

The following explains your obligation to this facility:

Appointments should be made on a daily basis either for chiropractic, physiotherapy, massage, or exercise sessions. If you are unable to attend for treatments on a certain day for any reason, you are to call our clinic to cancel your appointment for that day and reschedule your next appointment.

Please keep in mind that our priority is to our patients. However, we also have any obligation to your insurance company to report any absences or non compliance with the program.

MOTIVATION: Your recovery depends on how hard you work. We will teach you what you must do in your rehabilitation, but you must be prepared to give us your best effort. This effort will be reflected in your progress.

PROGRESS: Our program lasts approximately 8-10 weeks. We frequently
re-assess your strength, flexibility and range of motion. In order to justify ongoing treatment, we must see significant improvements. If you are working hard your body will make physiological response and we will see improvement.

YOUR RESPONSIBILITY: You must take an active role in your rehabilitation. If we do not see significant improvement, or if we feel that you are not committed to your recovery,) i.e. poor attendance, and/or compliance), we reserve the right to discharge you from our facility.

ATTENDANCE: Daily attendance is mandatory (unless otherwise specified). You are required to spend a minimum of 45-50 initially. The amount of time you spend on your program will increase as you progress through each phase. If for any reason you are unable to attend on any given day, you must call the centre and inform us why you will not be in. If you are away for more than three days we require a medical note from your family physician.

HOURS OF OPERATION: You must arrive at least 1 hour prior to closing time on any day. You will not be allowed to sign in if you are later then the above noted times.

SIGN-IN PROCEDURE: In order to ensure an accurate account of your attendance you must sign in at each visit. If your signature is not listed on the daily sheet, an absence will be recorded on your file.

CLOTHING: Wear clothing that is appropriate for active movements such as easy fitting pants, t-shirts and running shoes. Use of the gym equipment is prohibited. You may change your shoes and/or clothing at the centre, however there are no storage facilities.

SMOKING: The centre is a non-smoking facility.

I, ______________________ understand that the staff at Novo Healthnet Limited share the ultimate goal of getting me well. I have read and understood the contents of the forementioned list and agree to comply to the best of my ability.

I have received information on the program and understand the nature of the program and consent to it.

____________________________	______________________________
Signature	Date

____________________________	______________________________
Witness	Date

Informed Consent Form for Therapy Treatment of a Minor (under 18 years of age)

I understand that I am responsible for any and all outstanding payments and fees related to this treatment.

Patient Information

First Name:		Surname:	
Address: City:		Postal Code:	
Home Phone#:	Mobile #:	Email Address:	
Sex: M_____ F____		Date of Birth (mm/dd/yyyy): / /	
Name of Emergency Contact:	Relationship:	Home Phone: ( )	Work Phone: ( )

Parent/Guardian Information

First Name:		Surname:	
Address: City:		Postal Code:	
Home Phone#:	Mobile #:	Email Address:	
Sex: M_____ F____		Date of Birth (mm/dd/yyyy): / /	
Relationship to Patient:		Home Phone: ( )	Work Phone: ( )

______________________________ ______________________________

Parent/Guardian Signature Date

______________________________ ______________________________

Witness Date