RMT Intake

Name _____ Sex M F Date_____

Care Card # _____ Date of birth (mm/dd/yyyy) _____ Age_____

Address_____City_____ Province_____ Postal Code_____

Home Phone _____ Work Phone _____ Cell Phone_____

Would you like email or text appointment reminders? Please tick your choice and fill in your information below:

□ Email _____ □ Text (make sure cell# is above) □ No reminders

Medical Doctor_____ Occupation _____ Employer_____

Who referred you to this clinic? Google / Drove By / Friend / Fix Healthcare Sign / Other_____

Is this an ICBC claim? Claim #: _____ Injury Date (mm/dd/yyyy): _____

Would you like us to direct bill ICBC for your claim? Y / N Adjustor's name: _____ Adjustor's ph #: _____

Are we to direct bill your lawyer? Y / N Lawyer's name/office: _____ Lawyer's ph #: _____

Please note that we do not direct bill WCB for massage therapy services.

Please circle your insurance company below if you would like us to direct bill them.

Chambers of Commerce Group Insurance Plans · Cowan · the co-operators · Great-West Life · gsc · Industrial Alliance · Johnson · JG Johnston Group · Manulife Financial · Maximum Benefit · Pacific Blue Cross · Standard Life · Sun Life Financial

Plan # _____ Id # _____Primary's full name (if not you) _____

Primary's birthdate (mm/dd/yyyy) _____ Primary's Plan # _____ Primary's Id # _____

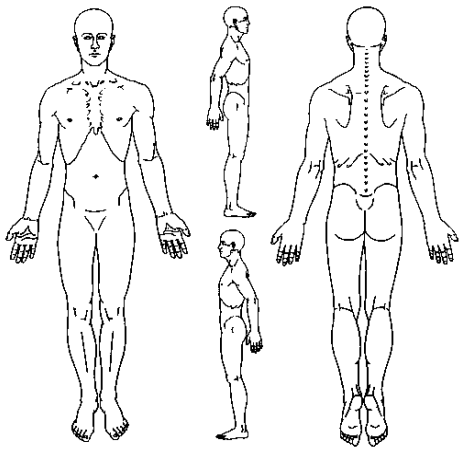
Have you ever received Massage Therapy? Yes No

Reasons for seeking Massage Therapy:

Primary Reason: _____

Secondary Reason: _____

Location of Complaint: Use drawing ---------->



A = ACHE	**C= CRAMPS**
P = PINS & NEEDLES/ TINGLING	**ST= STIFFNESS**
B = BURNING	**S = STABBING/SHOOTING**
N = NUMBNESS	**O = OTHER**

Complaint began when & how?

_____

Intensity/Severity (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst pain imaginable)

Does anything aggravate this condition? _____

Does anything relieve this condition? _____

Does this condition interfere with: (circle) Work Daily Routine Exercise Sleep

Rate the following 1(poor) to 5 (excellent): Sleep Patterns_____ Eating Habits_____ Exercise Habits_____ Water Consumption_____

What treatments have you tried? (circle) Chiropractic Medical Doctor Acupuncture Physiotherapist Naturopath Other:

_____

Please list and date any injuries/surgeries/other medical conditions:_____

_____

_____

What medications you are taking?_____

_____

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

- ❑ Limitation of movement, where _____
- ❑ Headaches, type _____
- ❑ Heart Disease
- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Stroke
- ❑ Cancer
- ❑ Arthritis
- ❑ Osteoporosis
- ❑ Dizziness
- ❑ Fatigue
- ❑ Insomnia
- ❑ Depression
- ❑ Altered Sensation
- ❑ Bleeding Disorders
- ❑ Phlebitis
- ❑ Varicose Veins
- ❑ Diabetes
- ❑ Pregnancy (past/currently)
- ❑ Menstrual problems
- ❑ Constipation
- ❑ Gastrointestinal Problems
- ❑ Hernia
- ❑ Eczema
- ❑ Psoriasis
- ❑ Contagious skin condition
- ❑ Allergies, type _____
- ❑ HIV/Aids
- ❑ Swollen joints
- ❑ Spinal Curvature
- ❑ Epilepsy

I have filled out this form to the best of my knowledge, if there are any changes to the above, I will inform the therapist.

If I am using my extended benefits, I authorize Fix Healthcare to direct bill on my behalf and receive payment for my treatments directly. I agree that I will be responsible for any fees which are not covered by my insurance, including those which may be initially accepted but later refused by my insurance.

In consideration of other patients and other practitioners, a minimum of 24 hours' notice is required to change or cancel appointments. This time has been reserved for you and unattended appointments prevent practitioners from seeing other patients. Patients will be expected to cover the full treatment fee in the case of missed appointments or late cancellations that cannot be booked by another patient. Please be advised that non-attended appointments cannot be billed to insurance providers. Thank you for your consideration.

_____ _____

Patient Signature **Date**

Please fill out this consent if you are eligible for Premium Assistance and would like us to bill on your behalf:

Assignment of Medical Services Plan Benefits to Opted-Out Practitioner

I, _____ (beneficiary) authorize the Medical Services Plan to pay my Practitioner directly for all reimbursements for benefits payable to me under the Medical and Health Care Services Regulation for care provided to me by said Practitioner. I make this assignment in full knowledge of the amount that I will be personally responsible for the patient portion of the fee and the amount that is reimbursable by the Medical Services Plan ($23.00). The amount reimbursed by MSP will be directed to the Practitioner checked above and be applied against any outstanding monies I owe for services provided. This form allows the practitioner to receive your MSP reimbursement directly for services that are MSP benefits. Our practitioner, by law, must advise you of his/her full fee and what portion will be reimbursed by MSP. By agreements, your practitioner may not charge you the portion reimbursable by MSP. **I understand that any appointments I receive over and above the 10 subsidized treatments per year will be my responsibility to pay at the private fee rates.**

Patient's Name: (please print) _____ Care Card Number (PHN):_____

Signature:_____ Date:_____

MASSAGE THERAPIST TO COMPLETE: INITIAL ASSESSMENT NOTES:

_____

_____

_____

_____