any body consulting
PHYSIOTHERAPY

1035 Manawagonish Road, Suite 2 Saint John,N.B. E2M 3X4
Tel: (506) 672-9355 Fax: (506) 635-8247
ABCphysiotherapy@bellaliant.com
"Physiotherapy for every body"
Owner: Robert M. Landers, Physiotherapist

Patient Intake Information

Client Name: _____ Date of Birth: _(month/day/year)____/____/____

Address: _____ Postal Code: _____

Phone #: (Home)_____ (Work)_____ (Cell)_____

Email Address: _____

Emergency Contact: _(Name)_____ (Number)_____

Physician Name: _____ Date of Last visit:_____

Patient Consent:
I hereby consent to examination and physiotherapy treatment by a licensed physiotherapist at Any Body Consulting & Physiotherapy. Any Body Consulting & Physiotherapy (ABC Physiotherapy) reserves the right to discontinue treatment at any time.

Client Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Payment Authorization: I, the undersigned, agree to pay all costs incurred for treatment to Any Body Consulting & Physiotherapy (ABC Physiotherapy) should my claim for physiotherapy through my personal insurance be disallowed or expire.
- see reception regarding inquiries related to billing and costs of treatment – (policy available)

Client Signature: _____ Date: _____

Witness Signature: _____ Date: _____

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Patient History Intake Form

Name:_____ D.O.B *(month/day/year)*_____/_____/_____ *Age:* _____

Please check the appropriate box for any of the following symptoms which you now have or have had previously. (you may choose not to fill in areas of this form until you are comfortable with the therapist – Please advise therapist)

Muscle & Joint		**Neurological**		**Respiratory**		**Heart**	
	Arthritis		Convulsions		Chest pain		Rapid heart rate
	Osteoporosis		Dizziness		Asthma		Slow heart rate
	Bursitis		Fainting		Difficulty breathing		Ankle swelling
	Rheumatoid		Nausea		Wheezing		High Blood pressure
	Psoriasis		Headaches				Low Blood pressure
	Neck pain		Loss of sleep	**Other**			Pain in chest
	Neck stiffness		Numbness		Aneurysm		Poor circulation
	Low back pain		Tingling		Diabetes		Heart conditions
	Hernia		Sweats		Cancer		
	Foot trouble		Loss of weight		Stroke		
	Spasms / Cramps		Epilepsy		Allergies		
	Other joint stiffness				Hepatitis		

Do you exercise?	**Do you Smoke?**	**Do you consume alcohol?**	
Do you SLEEP well?	**How many hours each night?**	**Do you wake through the night?**	
Past Motor Vehicle Accidents if any?		**Past Work Accidents, if any?**	
Past Illnesses:		**Present Illness:**	
Surgeries & Operations:			
Present Medications:			

Patient Consent

I hereby consent to examination and physiotherapy treatment by a licensed physiotherapist at Any Body Consulting & Physiotherapy. Any Body Consulting & Physiotherapy (ABC Physiotherapy) reserves the right to discontinue treatment at any time.

Dated:_____ Patient:_____ Witness:_____

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Consent to Release Confidential Information

I, _____(your name) with birthdate (month/day/year)_____/_____/____, do hereby authorize Any Body Consulting & Physiotherapy to communicate with, forward a copy of my clinical records and / or x-ray report to:

Family Physician: _____

Massage Therapist: _____

Specialist: _____

Chiropractor: _____

Insurance Company: _____

Other: _____

2nd Insurance Company _____

Thank you,

Client Signature: _____ Date: _____/_____

Witness Signature: _____ Date: _____/_____

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Insurance Information Collection & Authorization for Direct Billing

Client Name: _____ Date of Birth: (month/day/year)_____/_____/_____

Group Number: _____ ID Number: _____

Insurance Company: _____ Coverage maximum:_____

Co-Payment Percentage _____%

I _____(your name) authorize direct billing from **Any Body Consulting Physiotherapy (ABC Physiotherapy)** to bill _____(insurance company) on my behalf. Please pay provider directly for physical therapy services and products rendered for the dates specified on the current invoice as well as future invoices.

I, the undersigned, agree to pay all costs incurred for services from ABC Physiotherapy should my claim for physiotherapy through my personal insurance be disallowed or expire.

Client Signature: _____ Date: _____

Witness Signature: _____ Date: _____

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Email: ABCphysiotherapy@bellaliant.com

On the Web www.abcphysio.ca

Owner: Robert M. Landers, Physiotherapist

Our Privacy Commitment

At ABC Physiotherapy Clinic we are committed to protecting the privacy of personal information. We will not disclose personal information without consent or reasonable and lawful notice, except when required or permitted by law.

At ABC Physiotherapy Clinic we protect the privacy of patients by:

- Collecting only the personal information that is necessary for us to provide physiotherapy services to you.
- Advising how your information might be disclosed and obtaining your consent.
- Having safeguards in place to protect your personal information.
- Training staff and adapting the office space to ensure maximum protection of your privacy.
- Sharing your personal information only for the purposes with those agreed to in a signed consent form, or as otherwise permitted by law.
- Ensuring the personal information we have is accurate and up to date.
- Providing you with access to your personal information.
- Periodically reviewing our privacy policy to ensure we are adequately protecting your information.

If you have concerns about your personal information please feel free to speak with the Physical Therapist treating you or another staff member. If you have a concern that is not being resolved and you wish to discuss it further, please address you concern in writing to Robert Landers (privacy commissioner) at (506) 672-9355.

For further information on our privacy commitment please refer to the following link on our website at: www.abcphysio.ca

Patient's Signature_____

Witness' Signature_____

Date: _____/_____