

Consent Form

PHYSIOTHERAPY/OCCUPATIONAL THERAPY CONSENT TO TREATMENT

I hereby consent to the assessment and treatment performed by the Registered Physiotherapist/Registered Occupational Therapist/Registered Massage Therapist named below.

I understand that treatment may include treatments for therapeutic, preventative, diagnostic, or other health related issues.

I understand that I may revoke or amend this consent in writing.

I have read the above consent, and I have had the opportunity to ask questions about its content. This consent will cover the physiotherapy/therapy assessment and entire course of treatment.

Patient's Name (Please Print)

Therapist's Name

Date

Signature of Patient

How did you hear about Sather Reid Sport Medicine?

Family Physician	Healthpointe Physician	Staff Member	Friend/Family
Google	Instagram	Edmonton Sport Talk	
Community Event	Other:		

To receive email correspondence from our clinic, please provide your email address here:

Benefit Assignment Form

Instructions: This form must be filled out when claim payment is assigned to the Provider. Please retain this form in the patient's file for verification purposes for two years following closure of the patient file.

Provider: Sather Reid Sport Medicine

Address: #101, 190 Carleton Dr. / #302 575 St SW, Edmonton

City/Province: St. Albert, AB

Postal Code: T8N 6W2

Phone Number: (780) 460-9977

Patient: _____

Carrier Name: _____

Date of Birth: _____

Address: _____

City/Province: _____

Postal Code: _____

Phone Number: _____

Plan Number: _____

Group Number: _____

Member ID Number: _____

I hereby assign benefits payable for the eligible claims to the Provider responsible for submitting my claims electronically to the group benefits plan and I authorize the insurer/plan administrator to issue payment directly to the Provider. In the event my claim(s) are declined by the insurer/plan administrator, I understand that I remain responsible for payment to the Provider for any services rendered and/ or supplies provided.

I acknowledge and agree that the insurer/plan administrator is under no obligation to accept this Assignment, that any benefit payment made in accordance with this Assignment will discharge the insurer/plan administrator of its obligations with respect to that benefit payment, and that in the event the benefit payment is made to me, the insurer/plan administrator will also be discharged of its obligation with respect to that benefit payment.

I understand that this Assignment will apply to all eligible claims submitted electronically by the Provider and that I may revoke it at any time by providing written notice to the insurer/plan administrator.

If I am a spouse or dependent, I confirm that I am authorized by the plan member to execute an assignment of benefit payments to the Provider.

Date

Print Name

Signature

Electronic Transmission Authorization and Consent Form

Instructions: This form must be filled out when claims are submitted electronically by the provider on the patient's behalf. Please retain this form in the patient's file for verification purposes for two years following closure of the patient file.

Consent to Collect and Exchange Personal Information Message to the Plan member, Spouse and/or Dependent regarding Personal Information

Personal information that we collect and disclose about you, and if applicable, your spouse and/or dependents, is used by the insurer and/or plan administrator and their service provider(s) for the purposes of assessing your claims, underwriting, investigating, auditing and administering the group benefits plan, including the investigation of fraud and / or plan abuse.

Authorization and Consent

- 1) I authorize my healthcare provider to collect, use and disclose personal information concerning any claims submitted on my behalf with the insurer and/or plan administrator and their service provider(s) for the above purposes.
- 2) I authorize the insurer and / or plan administrator and their service provider(s) to:
 - a. use my personal information for the above purposes.
 - b. exchange personal information with any individual or organization, including healthcare professionals, investigative agencies, insurers and reinsurers, and administrators of government benefits or other benefits programs when relevant for the above purposes.
 - c. exchange personal information concerning any claims submitted with the plan member or a person acting on behalf of the plan member.
 - d. exchange personal information for the above purposes electronically or in any other manner.
- 3) I understand that personal information may be subject to disclosure to those authorized under applicable law.
- 4) I agree that a photocopy or electronic version of this authorization shall be as valid as the original, and may remain in effect for the continued administration of the group benefits plan.

Date	Print Name	Signature
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Additional Consent Applicable to Plan Members Only

I confirm that I am authorized by my spouse and/or dependents, if any, to disclose personal information about them to the insurer and/or plan administrator and their service provider(s) for the purposes described above and I confirm that my spouse and/or dependents also authorize the insurer and/or plan administrator and their service provider(s) to disclose information about their claims to me, for the purposes of assessing and paying a benefit, if any, and managing the group benefits plan. I also authorize my spouse and/or dependents to assign benefit payments under the plan to the healthcare provider.

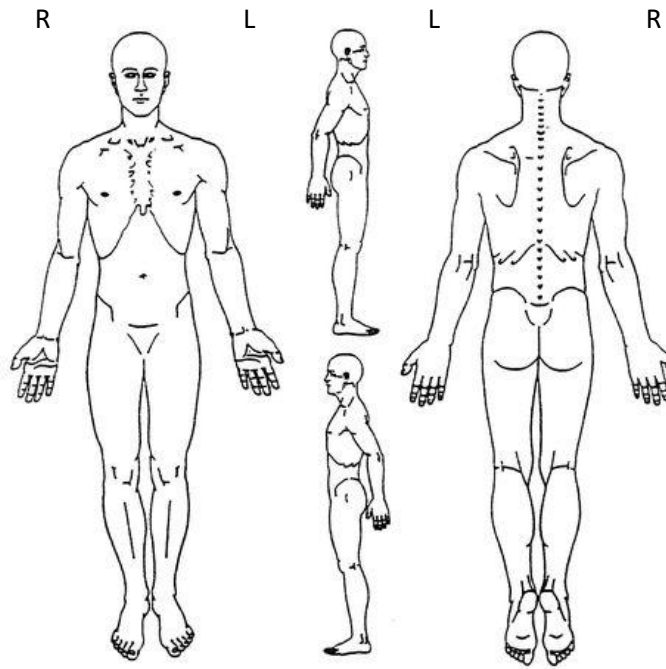
In the event there is suspicion and/or evidence of fraud and/or plan abuse concerning claims submitted, I acknowledge and agree that the insurer and/or plan administrator and their service provider(s) may use and disclose relevant personal information to any relevant organization including law enforcement bodies, regulatory bodies, government organizations, medical suppliers and other insurers, and where applicable my Plan Sponsor, for the purposes of investigation and prevention of fraud and/or plan abuse.

If there is an overpayment, I authorize the recovery of the full amount of the overpayment from any amount payable under the group benefits plan, and the exchange of personal information with other persons or organizations, including credit agencies and, where applicable, my Plan Sponsor, for that purpose.

Date	Print Name	Signature
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Health Screen

Pain Diagram – Please indicate area of pain or discomfort on the diagram below.



When did your pain start?

What caused your pain to start?

Do you have a history of other injuries or pain? Yes No

Do you have a history of surgical procedures? Yes No

Have you received any previous treatment for this injury? Yes No

Have you had any diagnostic imaging done on this injury? Yes No

Any additional comments:

Health Screen

Indicate if you have ever been diagnosed with any of the following health conditions:					
	Yes	No		Yes	No
Stroke			Osteoarthritis		
Diabetes			Rheumatoid Arthritis		
Epilepsy			Other Inflammatory Arthritis		
Osteoporosis			Depression/Anxiety		
Thyroid Dysfunction			Kidney Disease		
Cancer			Fibromyalgia/Chronic Pain Syndrome		
Tuberculosis			Heart Disease/Coronary Artery Disease		
High Blood Pressure			Other Heart Condition		
Asthma			COPD		
Pacemaker			Metal Pins, Plates, or Screws in Bone?		
Any other conditions not listed:					
Indicate if you have experienced any of the following symptoms:					
Chest Pain			Difficulty Breathing at Rest		
Nausea			Bowel Dysfunction		
Persistent Cough			Bladder Problems (ie leaking when you cough)		
Seizures			Dizziness or Fainting		
Blood Clots			Swelling in Legs or Feet		
Circulation Problems			Significant Weight Gain or Loss		
Please list any medications you are currently taking:					
Please list any allergies:					

The pelvic floor is an intricate network of muscles, ligaments, and tissues that provides crucial support to the organs in the pelvic region. Unfortunately, many people commonly experience pelvic floor issues that can significantly impact their quality of life

Pelvic Health Screen	Yes	No
Do you experience any leakage of the bladder or bowel?		
Do you experience any pelvic pain or pressure in the pelvis with: le. sitting, movements of the bowel or bladder, intercourse, cycles?		
Are you peri- or post-menopausal?		
Are you pre- or post-partum?		
Do you have chronic low back or hip pain that has not improved with regular physiotherapy?		

If you answered YES to any of the above questions, problems with your pelvic floor may be contributing to your symptoms / pain. You may be a candidate for an assessment with a pelvic floor physiotherapist trained in the area. Please indicate below if you would like more information from your Physiotherapist.

Pelvic Health	Yes	No
Do you wish to receive more information about pelvic health?		



Patient Demographics

In a continuous effort to maintain accurate and up-to-date contact information on our patients, we would ask that you take a moment to fill out the form below. Should your personal information change at any time we would greatly appreciate you contacting our office to advise us.

First Name: _____ Last Name: _____
Preferred Name: _____ Gender: _____
Mailing Address: _____ City: _____
Province: _____ Postal Code: _____
Personal Health Care: _____ Date of Birth (dd/mm/yyyy): _____
Cell #: _____ Other # (work/home): _____
Email: _____
Family Doctor (First & Last Name): _____
Clinic of Family Doctor: _____
Emergency Contact Name: _____ Phone #: _____
Relationship: _____

Do you have a pacemaker? Yes No

Are you Diabetic? Yes No

List all allergies:

Are you presently taking any of the following **blood thinners**? Y __ N __

- ☐ Warfarin
- ☐ Coumadin
- ☐ Plavix
- ☐ Baby Aspirin
- ☐ Other

If you wish to allow a family member or another source to be able to contact our office regarding some of your information such as appointments, please list them below.

Family Member

Other (please specify)

By my signature below, I give consent to Sather Reid Sport Medicine to disclose my information to the above mentioned. I understand that I may withdraw my consent at any time providing reasonable written notice to the clinic I am attending.

Signature

Date