AURORA SPORTS MEDICINE PROFESSIONALS INC.

NOBLETON PHYSIOTHERAPY

PATIENT REGISTRATION FORM - PHYSIOTHERAPY

Welcome to Aurora Sports Medicine Professionals Inc. / Nobleton Physiotherapy. Please take a moment to complete the following registrations forms. Thank you.

Date: _____ Title (please check): ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss.

Last Name: _____ First Name: _____ Initial: _____

Age: _____ Date of Birth (y/m/d): _____ Gender: ☐ M ☐ F

Address: _____ Apt/Ste/Box#: _____

City, Province: _____ Postal Code: _____

Home Phone #: _____ Work Phone #: _____

Cell Phone #: _____ Occupation: _____

Family Doctor: _____ Family MD Phone #: _____

How did you hear about us? ☐ Family MD Referral ☐ Word of Mouth ☐ Website ☐ Google
☐ Friend/Family member ☐ Other _____

Email Address: _____

Canadian legislation (CASL) now requires we gain your consent to communicate with you through email. Below is a list of items we may communicate to you through email. Please check the appropriate box(es).

Appt. Reminders: For your convenience, ASMP / NP can send email reminders for your upcoming appointments.
Would you like us to use your email for this service? ◯ Yes ◯ No Thanks

Health Professional Communication*:* During your treatment period your health provider may send you information regarding your injury or exercises to support your recovery.
Would you like us to use your email for this service? ◯ Yes ◯ No Thanks

Clinic Newsletter*:* On a semi-monthly basis we will be sending out a newsletter to update you on news/events within the clinic and educational tips for health and injury prevention.
Would you like us to use your email for this service? ◯ Yes ◯ No Thanks

Print Name: _____ Signature: _____

Date: _____

Pain Location: (please check those that apply)

Head ☐ Jaw ☐ Neck ☐ Shoulder ☐ Elbow ☐ Wrist ☐ Hand ☐ Upper Back ☐
Mid Back ☐ Lower Back ☐ Hip ☐ Knee ☐ Ankle ☐ Lower Leg ☐ Ribs ☐
Abdomen ☐ Other ☐ (specify) _____

Date of Injury/Onset of Symptoms: _____

Cause Of Injury:

Sport ☐ (specify) _____ Work ☐ Motor Vehicle Accident ☐ Unknown ☐

Current Pain Rating:

(Scale 0=no pain, 10=worst pain of life)

Previous Treatment for Problem: (please specify)

_____

Medical History: Please review the following medical conditions. Some of these conditions may affect the type of treatment we perform. (Please check those that apply currently or in the past)

Cancer ☐ Epilepsy/Seizures ☐ Respiratory Condition ☐ Osteoporosis ☐ Diabetes ☐

Heart Condition ☐ Digestion Problems ☐ Pregnancy ☐ Stroke ☐ Active Infections ☐

Blood Pressure Issues ☐ Bowel/Bladder Problems ☐ Arthritis ☐ (type) _____

Inflammatory Disease ☐ (specify) _____ Allergies ☐ (specify) _____

Past Surgery ☐ (specify) _____Other ☐ (specify) _____

Medications: (please list)

_____
_____
_____

Print Name: _____ Signature: _____

Date: _____

Tele Rehabilitation Consent Form

In light of COVID19, Aurora Sports Medicine Professionals Inc. & Nobleton Physiotherapy have switched some appointments to either phone-based or virtual tele rehab appointments if it is appropriate for your care.

We use all manners of protection and encryption that are required of us and use secure, online platforms. We understand the importance of protecting personal information.

By joining a phone or tele rehab appointment with Aurora Sports Medicine Professionals Inc / Nobleton Physiotherapy:

☐ I agree that I am attending **Aurora Sports Medicine Professionals Inc. / Nobleton Physiotherapy** to receive physiotherapy assessment/treatment virtually and not in person. I understand that part or all the assessment/treatment may take place on a secure teleconference platform due to social restrictions during the COVID-19 pandemic and/or other personal restrictions from attending the clinic such as distance or ability to travel.

☐ I agree that at any time during this session I can change my mind and stop the session from continuing.

☐ I agree in order to carry out the virtual session I will need to have a device (iPad/tablet, smartphone, laptop) that has camera and microphone capability and Google Chrome, Safari, or Firefox as a web browser.

☐ I agree that my tele-rehabilitation is an online virtual 1:1 session where the physiotherapist can assess and give me self-treatment recommendations and exercise. Assessment is done by watching me move, observation of the area of injury, and instructing me to perform special tests to my injury that a physio would normally perform. Treatment involves teaching self-management techniques, guided exercise, and lots of education to manage my injury at home. We may also send you a separate email that describes the exercises we are suggesting for you.

☐ We are using a secure web-based platform **Doxy.me** that follows both Canadian and American privacy rules and is **HIPAA, PHIPPA, and PIPEDA compliant**. There are some potential risks with technology including but not limited to interruptions, unauthorized access, viruses, and other involuntary intrusions that have the ability to grab and release private information. In order to minimize this risk we are providing this service within our clinic premises on our secured network. Doxy.me does not store any patient health information and all video calls are completely encrypted from peer to peer, meaning all data is between both participants only.

Tele Rehabilitation Consent Form (continued)

☐ If during the session there is a technology interruption or failure, the physiotherapist will contact me via phone to reconnect and continue the session. **Contact #** _____

☐ I understand that there is a treatment fee for this appointment payable at the end of my appointment time. Payment and receipts will be given electronically. If you have any concerns regarding tele rehab fees please let your therapist know.

☐ In case of an emergency, the physiotherapist will use the contact information on file to notify emergency services as required.

☐ Finally, upon completion of the session I will have the opportunity to ask any further questions from the physiotherapist.

☐ I agree to the above mentioned and give my consent to participating in tele rehab services provided by Aurora Sports Medicine Professionals Inc. / Nobleton Physiotherapy.

Patient Name: _____ **DOB:**_____

Physiotherapist Name: _____ **Date: _____**

Physiotherapist Signature: _____

Benefit Assignment Form – Extended Healthcare Coverage Information

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.

Patient: _____ DOB: _____

Address: _____

City/Province: _____

Phone Number:_____

Health Provider/Funder:_____

Name/Birthdate of Policy Holder: (if different from above)_____

Plan Number/Policy: _____ Certificate / Member Number: _____

Referral: Yes/No: _____

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 all fees by law will be forwarded to the extended healthcare plan (if available) initially and when benefits are depleted, the remainder of fees are forwarded to you the claimant.

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.

Cancellation Policy of 24 hours applies with all scheduled appointments. If appointment is cancelled without appropriate notice, normal fee will be applied.

Printed Name: _____ Signature: _____ Date:_____