Eastview
PHYSIOTHERAPY

Welcome to Eastview Physiotherapy

We are sorry to hear you have sustained an injury requiring medical attention. Our goal is to provide you with the most effective, personal and friendly care possible. During your first visit, a Registered Physiotherapist will perform a full assessment. This will be followed by appropriate treatment based on assessment findings.

Patient Information

please print clearly

Name _____ Phone Home _____

Address _____ Cell/Work _____

_____ Email _____

Postal Code _____ (email may be used for reminders and clinic events/info.)

Date of Birth (d/m/y)_____ Date of Injury _____

Physicians (family)_____ Areas of Injury _____

(specialist)_____ _____

Date of Referral _____ Referred to Eastview by _____

Treatment Fees

Extended Health Coverage or those **Paying Privately**:

Payment is required following the initial assessment and each Physiotherapy visit (payment following the last visit of each week may be considered). Payments can be made by cash, cheque, Visa, MasterCard or debit.

Treatment fees	**$90.00**	Initial Assessment / Treatment session
	$60.00	for each additional Treatment session
Senior rate (65 and older)	**$80.00**	Initial Assessment / Treatment session
	$55.00	for each additional Treatment session

Direct billing may be available for those with an Extended Health Plan Insurer which provides a direct billing service. Payment will be required for the balance of fees that are not covered by these plans.

Cancellation / No Show Policy

We ask that you contact the clinic in advance of any appointment that needs to be rescheduled or cancelled.
There will be a fee of **$20 for appointments missed without 24 hours notice**.
There is a fee of $25 for any NSF cheque.

WSIB or Motor Vehicle Insurance Claims.

Further details regarding coverage will be provided to you by our reception staff at the clinic. Please bring all insurance information to your initial visit. Thank you.

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Treatment Readiness Questionnaire

Yes/No

____ Have you missed work because of injury or pain in the last 6 months?

____ Have you been told by your doctor your blood pressure is too high?

____ Do you experience chest pain or have been told by your doctor you have heart trouble?

____ Do you have a pacemaker?

____ Do you often feel faint or have spells of severe dizziness?

____ Do you, or have you been diagnosed with cancer?

____ Have you ever had a seizure?

____ Are you diabetic?

____ Do you ever have difficulty breathing or have a history of asthma or emphysema?

____ Have you been diagnosed with any other condition? ie: OA, RA, Osteoporosis

____ Do you have problems with swelling in your lower extremities? (legs & feet)

____ Do you have any metal implants?

____ (females) Are you pregnant or trying to conceive?

____ Have you had any surgery/operation(s)? List: _____

____ Are you currently on any medication? List: _____

_____

____ Are there any physical reasons, not listed above, why you should not follow an active physiotherapy program even if you wanted to?

If 'yes', please list. _____

_____

Note: Please notify your therapist immediately of any changes in your status during your treatment.

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Consent to Release/Obtain Information

I hereby authorize any representative of Eastview Physiotherapy to:

1. Send copies or give a verbal report of my assessment, treatment plan, interim progress report(s), discharge plan and follow-up reports as applicable, to the individual(s) or organization(s) named below.
2. Contact any of the individual(s) or organization(s) named below for the purpose of obtaining information regarding my injury, functional/vocational needs, physical demands of my employment and return to work planning. Contact medical diagnostic centers for obtaining information (ie. x-rays) related to my injury.
3. Any question or concern relating to the privacy of information may be addressed to the Information Officer, Andy Penner, through Eastview Physiotherapy.

_____ _____
Physicians Insurance Company

_____
Employer

I have read and understood all of the above information and agree to accept responsibility as indicated.

_____ _____
Print Name Date of birth (d/m/y)

_____ _____
Signature of Client Date (d/m/y)