Synergy Sports Medicine & Rehabilitation - New Patient Form

Please be advised all Information is Private and Confidential.
Privacy Policy in place

Welcome, and thank you for choosing Synergy Sports Medicine & Rehabilitation. We offer quality professional health care. Direct and open communication between you and the staff is vital for proper care. We ask that you fill out the following forms to ensure that you receive the appropriate care that you require. Please note all information is confidential.

Please note that we do not accept MVA or WSIB claims.

Contact Information

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr. ☐ Sir

Given Legal Name: _____
First Name Last Name

Preferred Name: _____
(if different from above) First Name Last Name

I identify as: ☐Man ☐ Woman ☐Trans ☐Other _____
Address: _____
City: _____ Province: _____ Postal Code:_____
Phone: Home(____)_____ Work(____)_____
Email: _____
Date of Birth: Day_____ Month_____ Year_____
Occupation: _____ Hrs/week _____
Emergency Contact: _____ Phone _____

Medical Information

Family Physician: _____ Phone: (____)_____
Address: _____
City: _____ Province: _____ Postal Code:_____
Previous Treatment:

☐ Athletic Therapist ☐ Chiropractor ☐ Massage Therapist ☐ Acupuncturist ☐ Other
Name (or Clinic Name):_____ Date of Last Visit: _____

How did you hear about us?

□ Google
□ Advertisement (Location):_____
□ Walk In
□ Other: _____
□ Social Media _____
□ Media: _____
□ Referral: _____

Would you like to receive our quarterly newsletter packed with valuable free information, updates on promotions and courses offered at Synergy Sports Medicine & Rehabilitation?

_____ Yes, please include me on future mailings.

_____ No thank you.

Please see reverse…

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Consent Form

We want you to understand the services that we provide to you and what we do with the personal information that you provide to us. Please let us know of any questions that you have.

Assessment and treatment
Your health care professional will explain to you the procedure for assessment and treatment, and will ask for your consent. Please note that you have the right to ask questions or to withdraw consent at any time during your assessment and treatment.

Collection, use, storage and disposal of personal information
In order to provide health care services, Synergy Sports Medicine and Rehabilitation will collect select personal information from you (for example: contact information, address, health history).

Synergy has a Privacy Policy about the collection, storage, use and disclosure of personal information and about the protection of personal information. You have the right to review your personal information, and the Privacy Policy is available to you upon request. Please let us know of any questions that you may have.

Consent
I have read and understand this information, and give consent to Synergy Sports Medicine and Rehabilitation to:

1. Proceed with assessment and treatment
2. Collect, store and dispose of my personal information according to the Privacy Policy
3. Share my information with the following (provide name, phone number, address if possible):
   - Family physician _____
   - Specialist _____
   - Other health care practitioner's _____
   - Insurance company _____

Name _____

Signature _____

Date _____

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Fee Schedule
24 hour cancellation policy in effect for all services
All Prices Include HST if Applicable
Same Day Cancellation Fee: Half the rate of the Appointment
No Show Fee: Full Rate of the Appointment

Please note that we do not accept MVA or WSIB claims.

Registered Massage Therapy

30 Minutes	$62.00
40 Minutes	$84.00
60 Minutes	$103.00
90 Minutes	$145.00

Physiotherapy

Initial Physiotherapy Assessment	$110.00
15 Min Follow-Up Treatment	$55.00
30 Min Follow-Up Treatment	$75.00
45 Min Follow-Up Treatment	$110.00
60 Min Follow-Up Treatment	$125.00
Physiotherapy/Rehabilitative Pilates	$125.00

Chiropody

Initial Assessment	$60.00
Orthotics	$500.00
Follow up Chiropody Visit	$40.00

Private Pilates

60 Minutes	$90.00 - $110.00
30 Minutes	$55.00

NSF Cheques $35.00 Total

PAYMENT DIRECTION

I, _____ hereby agree that I have read and clearly understand the above information, I fully understand the fees for service and am aware that I am responsible to make payments for any services provided.

Date: _____
day month year

_____

Patient Signature

*Prices subject to change without notice

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Email Communication Consent Form for Patient/Substitute Decision Maker

I, _____, acknowledge that I have read and fully understand this consent form. By signing this form I agree that:

- I wish to use email as one of the ways in which to receive communication with clinicians/staff associated with Synergy Sports Medicine & Rehabilitation.
- I understand the risks associated with communication by email between Synergy Sports Medicine & Rehabilitation clinicians/staff and me, and I consent to the conditions and responsibilities outlined in the accompanying **email communication letter** dated May 9, 2013.
- I will comply with any further instructions that the Synergy Sports Medicine & Rehabilitation clinicians/staff may impose to communicate with patients/substitute decision makers by email in the future.
- I acknowledge the rights of the Synergy Sports Medicine & Rehabilitation Medicine clinicians/staff to, upon the provision of written notice, withdraw the option of communicating by email.
- I hereby waive, release, and discharge from any and all liability, Synergy Sports Medicine & Rehabilitation, its employees, and all physicians connected in any way with me as a patient, for any complications which may arise from the use of email.
- I indemnify and hold harmless the entities or persons noted above from any and all liabilities or claims made by other individuals or entities as a result of my decision.
- I agree to abide by the terms of this agreement and consent.
- Any questions I may have had were answered to my satisfaction.

Email address (please print clearly) _____

☐ Signature of Patient/ ☐ Substitute Decision Maker _____

☐ This consent for email communication also applies to the records of my dependent children under 16 years of age (if applicable).

In order to allow us to provide you with the best possible care, please fill out this form as accurately as possible.

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Please Note all information is strictly confidential. Please ask about our privacy policy.

Medical History

Previous Hospitalizations:(surgery, illness etc.)_____

Other Injuries:(MVA, dislocation, sprain etc.)_____

For Women – No. of Pregnancies:_____ No. of Children: _____

Are you pregnant? ❑ Yes ❑No

Painful or heavy menstruation? _____ Menopause? _____

Do you have or have you ever had:

- ❑ Crohn's/Colitis
- ❑ Gall Stones
- ❑ Stomach/GI Ulcer
- ❑ Tuberculosis
- ❑ Chicken Pox/Shingles
- ❑ Poor Circulation
- ❑ Phlebitis
- ❑ Congestive Heart Failure
- ❑ Stroke
- ❑ Rashes/Eczema
- ❑ Varicose Veins
- ❑ Bruise Easily or Bleeding Disorder
- ❑ Sensitive Skin
- ❑ Problem Acne
- ❑ Rheumatoid Arthritis
- ❑ Plantar warts of the feet/hands
- ❑ Psoriasis

Do you have or did you ever have:

- ❑ Allergies
- ❑ High/Low Blood Pressure
- ❑ Dermatitis
- ❑ Prolonged Bleeding
- ❑ Heart Disease
- ❑ Lung Disease
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Diabetes
- ❑ Cancer Type:_____
- ❑ Hepatitis
- ❑ HIV/AIDS
- ❑ Thyroid Disease
- ❑ Sexually Transmitted Infection
- ❑ Seizures

Other:_____

Family Medical History:

- ❑ Allergies
- ❑ High/Low Blood Pressure
- ❑ Dermatitis
- ❑ Prolonged Bleeding
- ❑ Heart Disease
- ❑ Lung Disease
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Diabetes
- ❑ Cancer
- ❑ Thyroid Disease
- ❑ Migraines
- ❑ Seizures

Are you taking Prescription Medications? Please list:

_____

_____

_____

_____

_____

_____

Are you taking any:

- ❑ Supplements
- ❑ Vitamins
- ❑ Herbs
- ❑ Antacids

Please list:

_____

_____

_____

Other:_____

What is your main complaint? (if you have been given a medical diagnosis please include it):

_____

How long have you had this complaint?:

_____

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Systemic

Please check any complaints you currently have and indicate the severity:

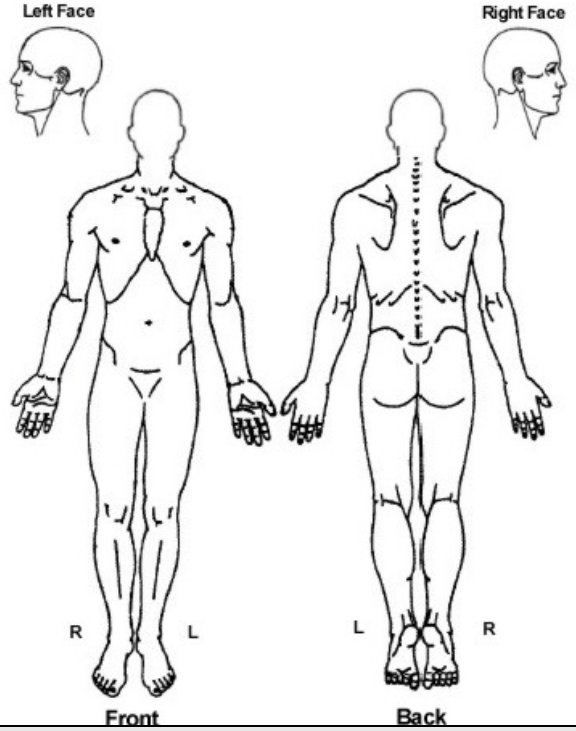
	most		least		most		least
❑ diarrhea	❑	❑	❑	❑ tinnitus	❑	❑	❑
❑ constipation	❑	❑	❑	❑ shortness of breath	❑	❑	❑
❑ abdominal discomfort	❑	❑	❑	❑ asthma	❑	❑	❑
❑ poor appetite	❑	❑	❑	❑ dizziness	❑	❑	❑
❑ fatigue	❑	❑	❑	❑ difficulty concentrating	❑	❑	❑
❑ vision problems	❑	❑	❑	❑ stress	❑	❑	❑
❑ vision loss	❑	❑	❑	❑ depression	❑	❑	❑
❑ hearing loss	❑	❑	❑	❑ insomnia	❑	❑	❑

Other:_____ _____

In the diagrams provided below, please mark the areas on your body, which you feel best represent the pain or sensation(s) you are experiencing. Please include all areas. Use the symbols provided below.

Symbols:

	_____		::::::::::::		xxxxxxxx
Numbness:	_____	Pins & Needles:	::::::::::::	Burning:	xxxxxxxx
	oooooo		+++++++		2222222
Stabbing & Sharp:	oooooo	Dull & Aching	+++++++	Stiff & Tight:	2222222



Please rate your level of pain along the line, with "None" being no pain at all, and "Max" being the worst pain you have ever felt.

None Max

Lifestyle

Please check all that apply:

- ❑ alcohol — No. of drinks (e.g. wine, spirits, beer) per week: _____
- ❑ caffeine — No. of drinks (e.g. coffee, tea) per day: _____
- ❑ smoking — No. of cigarettes per day: _____
- ❑ exercise — No. of hours per week: _____ Type of Exercise: _____