Patient Information

Physiotherapy

Tuxedo Physiotherapy
156-2025 Corydon Avenue
Winnipeg, Manitoba R3P 0N5
(204) 885-1109

Name: _____ _____ _____
Last First Initial

Date of Birth (dd/mm/yy): _____ Identifying Gender: _____

Address (#, Street Name): _____

City/Prov: _____ Postal Code: _____

Cell Phone: (____) _____ Home Phone: (____) _____

Work Phone: (____) _____ Ext: _____Email Address: _____

Preferred method of contact: Phone Email Who referred you? _____

Occupation: _____ Employer: _____

Emergency Contact: _____ Phone Number: (____) _____

Relationship to patient:_____

Consent for Assessment and Treatment

I understand that my physiotherapist is providing physiotherapy services within their scope of practice. In understand that my physiotherapist will collaborate with me in making decisions regarding assessment and treatment. I acknowledge that with any treatment there can be risks, those risks have been explained to me and I assume such responsibility as well as potential for forgoing the suggested care. I should discuss any questions about my treatment and rehabilitation with my physiotherapist.

☐ I agree

Cancellation/No Show Policy

Your appointment time is reserved for you. We require 24 hours' notice for any cancellations. Patients who provide less than 24 hours' notice will be charged a $30 cancellation fee. Patients who do not cancel and do not show up for their appointment will be charged a $45 no show fee.

☐ I am aware of the Cancellation/No Show Policy

Physiotherapy Fees and Services

Payment for services are the responsibility of the patient and are to be paid for at each visit. If a third-party payer (i.e. WCB, MPI) denies my claim and/or refuses to pay for the full amount billed, I am responsible for paying the outstanding amount. I understand that I am responsible for any reimbursement provided by any other private insurance companies such as Blue Cross, Great West Life etc.

☐ I agree

Consent for Communication/Release of Information

I authorize the clinic and its associated health professionals to communicate with my doctor, massage therapist, dentist, chiropractor, naturopathic doctor or others deemed as necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

☐ I agree

☐ I do not want my information shared with my other health care practitioners.

Email Communication

Effective July 1, 2014, Canada's new anti-spam legislation requires us to secure your consent so that we can communicate with you electronically.
We would like your permission to send you the following:

☐ Email reminders of upcoming appointments

☐ Instructions and videos regarding prescribed exercises and updates regarding the same.

☐ Notifications regarding upcoming classes/workshops/services.

Name of Patient: _____ Name of Guardian (if applicable): _____

Signature: _____ Date: _____
Patient or Guardian

Please complete this section if you have a third-party insurer:

Name of Insurer: _____ Contract/Policy #: _____

Name of subscriber (if not yourself): _____

Please complete this section if your treatments are as a result of a Worker's Compensation or Autopac Claim:

WCB/MPIC Claim No.: _____ Adjudicator/Adjustor's Name: _____

If this is an MPIC claim, please specify the location of your claims center: _____

MPIC Injury Claim No.: _____

If this is a WCB claim, please complete the following:

Employer: _____ Address: _____

To expedite the processing of your claim, please ensure that all forms have been completed by your employer and yourself and forwarded to WCB

Medical Information:

Referring Doctor/Professional: _____

Address: _____ Phone Number: (____) _____

Family Doctor (if different from above): _____

Address: _____Phone Number: (_____) _____

List any other health care providers that are involved in your care for your injury (name and contact information)

_____

Please list any surgeries, X-Rays, MRI's, CT Scans or Bone Scans:

_____

Please list any hospital stays and reason:

_____

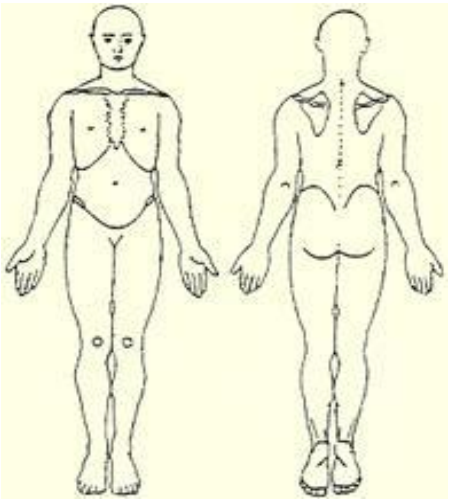
Please List current medications:

_____

Have you taken any Advil or Tylenol in the last 48 hours? YES ☐ NO ☐

Presence of: Pacemaker ☐ Artificial Joints ☐ Internal Wires/Pins ☐

Please circle your area of complaint(s) on diagram
Indicate the type of pain/discomfort A=Achy, D=Dull, S=Sharp, B=Burning, N=Numbness, P=Pins & Needles



Primary Pain Area: _____

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

No pain Moderate Pain Unbearable Pain

Secondary Pain Area: _____

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

No pain Moderate Pain Unbearable Pain

Click here to email to clinic

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