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: (____) _____

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 Policy

Your appointment time is reserved for you. We require 24 hours' notice for any cancellations. Patients who provide less than 24 hours' notice or miss their appointment, will be charged a $25 cancellation fee.

☐ I am aware of the Cancellation 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 (if patient is under 18)

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 ☐

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 form