205 Marycroft Avenue, Unit #3
Woodbridge, Ontario L4L 5X7
Tel: 905.265.8870 Fax: 905.265.8871
www.bodymed.ca info@bodymed.ca

BodyMed Rehabilitation Centre Inc.

"DEVOTED TO THE INDIVIDUAL NEEDS OF ALL OUR PATIENTS"

Welcome to BodyMed! Our team of healthcare professionals develop individualized rehabilitation programs. It is our goal to ensure that you receive the highest level of care and dedication with every visit to our clinic. Please take a moment to read and understand the policies and procedures of this clinic. Thank you kindly for your support.

Costs related to treatment may be covered through an extended healthcare plan with your employer, auto insurance carrier, the Workplace Safety and Insurance Board (WSIB), or other related group insurance policies (e.g., athletic organizations). **Health and accident insurance policies are arrangements between an insurance carrier and the respective patient.**

All services delivered to the patient are charged directly to the patient. BodyMed is not responsible for anything that is not covered through your insurance and as such, the patient is responsible for all payments to BodyMed Rehabilitation Centre Inc. It is clinic policy that payment is due when services are rendered, unless other arrangements are made in advance with BodyMed. BodyMed accepts Cash, Cheque, Interac, or Credit Card (Visa, Mastercard, American Express). Any inquires regarding other fees, tax receipts, office hours, insurance forms, diagnostic imaging, healthcare products, etc., can be addressed at our front desk.

Please note that cancellation of any appointment must be made 24 hours prior to the scheduled time slot. If you fail to notify the clinic within the 24 hours, a $25.00 fee may be applicable.

I have read and understand all of the statements presented in this document. I agree that health and accident insurance policies are arrangements between an insurance carrier and myself. I agree that all services given to me are charged directly to me and that ***I am responsible for payment to BodyMed Rehabilitation Centre Inc.*** *Any invoices sixty days overdue may be subject to an 18% interest charge.*

Name (print):_____

Signature (if under 18 years old, must be signed by parent/guardian):_____

Date:_____

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BODYMED

Informed Consent to Treatment

I hereby request and consent to the performance of assessments, various modes of physical therapy, manipulations, mobilizations, laser therapy and other procedures on me by the practitioners listed at this clinic or anyone working at this clinic authorized by the practitioners. I understand that I will be assessed prior to starting any treatment program and periodically throughout the course of treatment. I also understand that results cannot be guaranteed.

I understand and am informed that, as in all health care, there are some risks to treatment including but not limited to short term aggravation of symptoms, muscle or ligament strains and disc injuries. I do not expect the health practitioner to be able to anticipate and explain all risks and complications and I wish to rely on the health practitioner to exercise judgment during the course of the procedure which the therapist feels at the time, based upon the facts then known, is in my best interest. I understand that the laser can cause damage to the eyes when viewed directly and that laser safety eyewear, supplied by this clinic must be worn by me during laser treatments

I have read the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the examination and treatment for any condition that I may seek therapy for at BodyMed. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) in this clinic.

TO BE COMPLETED BY PATIENT:

Print Patient's Name	Witness
Signature of Patient (or Parent / Guardian)	Date Signed

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Confidential Patient Information

Patient Name:_____ Date: _____
First name *Last name*

Address:_____ Apt #:_____ City:_____

Province:___ Postal Code:_____ Home Tel. #:_____ Work Tel. #:_____

Date of Birth: _____/_____/_____ Cell #_____ Email**:**
day month year
(for: appointment reminders, promotions, notifications)

How did you find us?

[ ] Google [ ] Friend/Family [ ] Doctor Referral
[ ] Facebook/Twitter Name:_____ Doctor's name:_____
[ ] Other: _____ [ ] Website

Do you have any of the following Extended Health Insurance? POLICY #_____
CERT.#_____
Great West Life [ ] Sun Life [ ] Greenshield [ ] SSQ Financial [ ] Blue Cross [ ] Standard Life [ ] MDM Insurance [ ] Johnson Inc. [ ]
Maximum Benefit or Johnston Group [ ] Chambers of Commerce [ ] Industrial Alliance [ ] Cowan Insurance [ ]

Does your spouse have the following Extended Health Insurance? POLICY #_____ CERT.#_____
Great West Life [ ] Sun Life [ ] Greenshield [ ] SSQ Financial [ ] Blue Cross [ ] Standard Life [ ] MDM Insurance [ ] Johnson Inc. [ ]
Maximum Benefit or Johnston Group [ ] Chambers of Commerce [ ] Industrial Alliance [ ] Cowan Insurance [ ]

Is this a Motor Vehicle Accident Claim? yes [ ] no [ ]
If yes, Accident date: _____ Insurance Company: _____
Adjustor: _____ Telephone: _____
Claim #: _____ Policy #: _____

Is this a Workers' Compensation Claim? yes [ ] no [ ] S.I.N.: _____
If yes, accident date _____ Claim # _____
Employer _____ Tel. # _____ Contact: _____
Address: _____ City: _____ Postal Code: _____
WSIB Adjudicator: _____ Telephone #: _____

Family Doctor: _____
Telephone #_____
Address:_____

Providing consent for the purpose of sharing health information such as progress notes to my family doctor.

What problems concern you now? _____

Please check all the areas that apply to you:

respiratory problem	[ ]	heart problems	[ ]	diabetes	[ ]	cancer	[ ]
skin problems	[ ]	epilepsy	[ ]	hepatitis	[ ]	tuberculosis	[ ]
kidney problems	[ ]	stroke	[ ]	pregnant	[ ]	multiple sclerosis	[ ]
blood pressure: high	[ ]	low	[ ]				

List any other medical conditions:_____
List any surgeries:_____
Are you taking any medication ? yes [ ] no [ ] If yes, which? _____

Have you had past therapy such as physiotherapy/chiropractic/massage? yes [ ] no [ ]
If yes, when? _____ where? _____

I have understood and answered all parts of this document to the best of my knowledge.

Signature (if under 18 years old, must be signed by parent/guardian)_____Date:_____