OASIS
MISSION PHYSIOTHERAPY

Orthopaedic **A**nd **S**ports **I**njury **S**ervices

Registered Phytiotherapists: Joe Harvard MScPT, MCPA | Liliana Harvard BScPT, CAFCI, MCPA
Erl Pettman MCPA, FCAMT, OMT | Nasan Mohajeri MScPT, MCPA, CAFCI | Kim Hauvre MScPT, MCPA

Today's Date:_____

Name:_____Date of Birth: _____

Address:_____Postal Code:_____

Main phone: _____ Accept appointment reminders test to this phone Yes No

Alternate phone number: _____

Email address:_____

Accept appointment reminders to email address Yes No

Care card number (PHN): _____

Family physician:_____

Other treating Physicians (specialist/surgeon)_____

Please indicate how you heard about our clinic: _____

If you would like us to submit claims to a 3rd party payer on your behalf, the information we require to set that up is on a subsequent page of this form.

***IMPORTANT* For ALL patients:**

- **I am of the understanding that if for any reason a 3rd party payer does not cover any or all of the cost of my treatment, I am responsible to pay all PRIVATE RATE FEES owing. Accounts in arrears for over 6 months are subject to being submitted to a third party to collect on our behalf.**
- **1 business day cancellation notice is required to be able to offer optimum care to all patients. (A $30 fee will be implemented if no notice is given). If repeated appointments are missed, clients may be asked to pre-pay for the appointment prior to scheduling. This fee will not be refunded or transferred.**

SIGNATURE_____DATE_____

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Please indicate any of the following conditions that <u>you</u> have:

	Yes	No		Yes	No		Yes	No
Arthritis			Asthma			Vision difficulties		
Diabetes			Bronchitis			Swallowing difficulties		
Thyroid Condition			Other respiratory condition			Slurred speech		
Dizziness/fainting			Hearing impairment			Memory problems		
Low/high blood pressure			Pregnancy			Balance problems		
Heart condition			Metal implants (inc IUD)			Recent falls/blackouts		
Chest pain			Hernia			Unexplained weight loss		
Pacemaker			Depression			Groin numbness/tingling		
History of cancer			Osteoporosis			Bowel/bladder difficulties		
Allergies to tape/latex			Smoking history			Headaches		
Any allergies			Raynaud's			Blood disease		
Epilepsy/seizures			Sleeping problems			Other:		
Shortness of breath			Cough					

Surgeries: (with approx. dates) _____
Previous injuries (with approx. dates)_____
Injections (with approx.. dates_____

Do you sleep through the night? Yes No
Do you wake but feel unrested? Yes No
What position do you sleep in? Lying on: Back Front Side

Is there anything else we should know about your health? _____

Do you have a return appointment with the doctor who assessed you? Yes No

What areas of your daily life do you find are affected by the concern you are here to have addressed?

_____

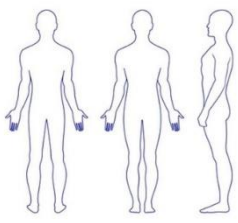
Please list any medications (with dosages) you are currently taking:
If you have a list, we are happy to make a copy for you

_____

Have you had any of the following for the condition for which you are currently referred?

X-rays	Yes	No	CT scan	Yes	No
EMG/nerve conduction	Yes	No	MRI	Yes	No
Bone density study	Yes	No	Ultrasound	Yes	No

Other:_____



Please indicate with an X your main area(s) of concern for today's assessment

Consent to assessment and treatment:

_____ _____
Signature Date

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Please read and complete the following if you would like OASIS Mission Physiotherapy to make claims to a third party payer on your behalf.

Please note the following:

- You are solely responsible for all fees owing to OASIS Mission Physiotherapy. If for any reason those fees are not paid in full by your 3rd party payer, you will receive an invoice for the amount owing; expected to be paid in a timely manner.
- You are responsible for understanding your benefits. This includes any deductibles or limits to your plan and any limits to length of time or number of visits covered by ICBC. We will do our best to collect the correct co-pay on the day of your treatment but adjustments may be made later.
- If for any reason we are unable to confirm what coverage is in place from your 3rd party payer, we will collect the full fee for your visit from you and assist you in any way we can to recover that fee from your 3rd party payer.

Extended Health Benefits Plans

Patient Name*: _____ Patient DOB*: _____

Policy Holder Name*: _____ Policy holder DOB*: _____

Relationship to Insured*: _____ Insurance Provider*: _____

Policy/Plan ID*: _____ Member ID*:_____

Deductible: _____ Yearly Max: _____ Max Payout per visit: _____

Percentage of coverage: _____

○ I provided OASIS with a current doctor's referral from Dr:_____

We can attempt claims to the following providers: CINUP, Chambers of Commerce, Cowan, Desjardins, First Canadian, GWL, Greenshield, Industrial Alliance, Johnson, Johnston Group, Manulife, Maximum Benefit, SSQ, Sun Life

* Required information. All other details about your insurance are valuable things for you to know. We do not know and cannot find out these details for you. If you ever have a visit that is not covered as you expect by your plan, knowing these details can help explain why.

ICBC

Claim Number: _____ Date of injury: _____

ICBC Adjuster: _____ Contact: _____

Lawyer: _____ Contact: _____

I have read, understood, and agree to the above information regarding 3rd party payers.

_____ _____ _____

Signature Print name Date