OASIS
MISSION PHYSIOTHERAPY

Private Insurance Paperwork

Orthopedic and Sports Injury Services
1 – 7650 Grant Street, Mission, BC V2V 3T3
Phone: 604-820-8285 Fax: 604-820-8287
info@oasismissionphysio.com

Registered Physical Therapists:

Joe Harvard MSc. PT
Kim Hauvre MSc. PT
Liliana Harvard BSc. PT; Acupuncture Foundation of Canada Certified
Gilbert Lapurga BSc. PT; Certified Work/Functional Capacity Evaluator

Name:_____ Date of Birth (DD/MMM/YYYY): _____

Address:_____ City:_____ Postal Code:_____

Home Phone: _____
Accept text reminders to this phone ___Yes ___ No

Cell Phone: _____
Accept text reminders to this phone ___Yes ___ No

Work Phone: _____

Email: _____
Accept text reminders to this email ___Yes ___ No

Care Card Number (PHN): _____

My visit is: ____ Private _____ ICBC _____ WSBC

Family Physician:_____ Location: _____

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 (Private Insurance, ICBC or WSBC) on your behalf, please complete page 3.

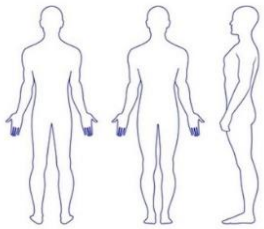
Important Notice to all patients:

- I understand that I am 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, or it was not submitted in a timely manner from our office, you are responsible to pay all outstanding amounts.
- Accounts in arrears for over 6 months are subject to being submitted to a third party to collect on our behalf.
- I understand that one business day cancellation notice is required to be able to offer optimum care to all patients. A $30 late cancellation 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.

Patient/Guardian Signature:_____ Date:_____

MEDICAL HISTORY

Check off Yes or No for the following conditions								
	Yes	No		Yes	No		Yes	No
Arthritis			Heart Condition			Vision Difficulties		
Osteoporosis			Chest Pain			Swallowing Difficulties		
Asthma			Pacemaker			Slurred Speech		
Bronchitis			Dizziness or Fainting			Memory Problems		
Other Respiratory Condition:			High or Low Blood Pressure			Hearing Impairment		
Cough			Depression			Sleeping Problems		
Diabetes			History of Cancer			Balance Problems		
Thyroid Condition			Smoking History			Recent Falls or Blackouts		
Raynaud's			Pregnancy			Unexplained Weight Loss		
Epilepsy or Seizures			Metal implants (incl. IUD)			Groin Numbness or Tingling		
Blood Disease			Hernia			Allergy to Tape or Latex		
Headaches			Bowel or Bladder Difficulties			Other Allergies:		



Back Front Side

Mark an X on your area or areas of concern.

How is your daily life affected by your condition?

_____

Anything else we should know about your health?

_____

Please list any surgeries, injuries or injections you have had with the approximate dates:

Injuries:_____

Surgeries: _____

Injections:_____

Please list any medications (with dosages) you are currently taking: If you have a list, we will copy it for you.

_____

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

Check off any test(s) you have had that are related to your referral in our clinic today?

___Bone Density Study ___CT Scan EMG/Nerve Conduction ___MRI ___Ultrasound ___X-rays

Other tests not listed above: _____

Do you have a referral from your doctor? ___Yes ___No

Do you have a follow up appointment with your doctor? ___Yes ___No

I give consent for Assessment and Treatment

Patient/Guardian:_____ Date:_____

PRIVATE INSURANCE CONSENT FORM

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

I understand that I am 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, or it was not submitted in a timely manner from our office, you are responsible to pay all outstanding amounts. _____ Initials

I understand if my account is in arrears for over 6 months it is subject to being submitted to a third party to collect on our behalf. _____ Initials

I understand that I am responsible for understanding my benefits such as deductibles, limits to my plan and any limits to length of time or number of visits covered. _____ Initials

If 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 will provide you with a receipt to recover that fee from your 3rd party payer. _____ Initials

Extended Health Benefits Plans

We do not have access to the details of your plan, so it is important for you to understand your coverage. If you have a visit that is not covered, knowing these details can help explain why.

Patient Name: _____ Patient DOB: _____

Policy Holder Name: _____ Policy holder DOB: _____

Insurance Provider: _____ Relationship to Insured: _____

Policy/Plan ID: _____ Member ID: _____

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

Percentage of coverage: _____

We will do our best to collect the correct co-pay on the day of your treatment, but adjustments may be made later.

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

Patient/Guardian Signature:_____ Date:_____