RNS Health & Wellness Centre
FOCUS ON YOUR HEALTH TODAY FOR A BETTER TOMORROW

Intake Form

Personal Information

Last Name: First Name: DOB (mm/dd/yyyy):

Gender: ☐ Female ☐ Male ☐ Other

Home Address: Apartment Number:

City: Province: Postal Code:

Email Address: Primary Phone #: Alternate Phone #:

☐ I would like to receive email reminders of my appointments
☐ I would like to receive RNS's newsletter as well as information about promotions and upcoming events.

Emergency Contact Person: Relationship: Contact Phone #:

Family Doctor: _____

Referring Physician or NP: _____ ☐ Same as Family Doctor

How did you hear about our clinic? _____ (e.g. Internet, Drive By, Family/Friend, Social Media, Physician, etc.).

Coverage Type

☐ No Coverage

☐ Extended Health Benefits (Complete Section Below)

☐ Motor Vehicle Accident (MVA) (Complete Additional Form)

☐ Workplace Injury (WSIB) (Complete Additional Form)

Extended Health Benefits Information

Name of Insurance Company: Name of Policy Holder: (☐ Self): Policy Holder DOB (mm/dd/yyyy):

Policy Holder's Relationship to Patient: Policy / Claim #: ID / Certificate #:

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Patient Medical History

Please mark ☑ for all current conditions, and mark ☒ for all past conditions.

Head/Neck
__ Headaches
__ Migraines
__ Vision problems/loss
__ Hearing loss/impairment
__ Vertigo
__ Tinnitus/Ringing in Ears
__ Earache/Infections
__ Dizziness/Fainting
__ Seizures/Epilepsy
__ Whiplash
__ TMJ/Jaw Pain
__ Other _____

Respiratory
__ Persistent Cough/Wheezing
__ Allergies? _____
__ Anaphylaxis
__ Asthma
__ Shortness of Breath
__ Emphysema
__ Enlarged Glands
__ Fever
__ Other
_____

Cardiovascular
__ Low Blood Pressure
__ High Blood Pressure
__ Heart Attack
__ Heart Disease
__ Palpitations/Irregular Heart Beat
__ Poor Circulation
__ Hyper/Hypoglycemia
__ Stroke
__ Varicose Veins
__ Congestive Heart Failure
__ Pacemaker
__ Swollen Ankles
__ High Cholesterol
__ HIV/AIDS
__ Anemia

Digestive/Urogenital
__ Poor/Excessive Appetite
__ Eating Disorder
__ Unexplained Weight Loss
__ Thyroid Problems
__ Constipation/Diarrhea
__ Crohn's/Colitis/IBS
__ Nausea/Vomiting
__ Rheumatic Fever
__ Liver/Gallbladder/Kidney Problems
__ Hepatitis
__ Frequent/Painful Urination
__ Blood in Urine
__ Kidney/Gall Stones
__ Type 1/Type 2 Diabetes
__ Ulcer
__ Hernia
__ Prostate Last Exam: _____

Skin Conditions
__ Eczema
__ Psoriasis
__ Sensitive Skin
__ Rashes/Eruptions
__ Allergies to Lotions/Tape/Latex
__ Bruise Easily
__ Phlebitis
__ Loss of Sensation
__ Lumps
__ Warts
__ Contagious Condition
__ Other: _____

General
__ Arthritis - Type: _____
Location? _____
__ Osteoporosis/Osteopenia
__ Scoliosis
__ Tuberculosis
__ Fibromyalgia
__ Cancer
Type: _____
__ Neurological Condition
MS/Parkinson's/CP
__ Poor or Loss of Memory

Women
__ Pregnant? # of wks _____
__ Number of Children _____
__ Caesarean Section
__ Menopause
__ Gynecological Condition
__ Irregular Menses
__ Ovarian Cysts
__ Other: _____

Prescription Medications
_____
_____
_____
_____
_____

Over the Counter Medications/Supplements
_____
_____
_____
_____

Fractures/Falls/Trauma

1) _____
Date: _____

2) _____
Date: _____

3) _____
Date: _____

4) _____
Date: _____

Surgeries/Hospitalizations

1) _____
Date: _____

2) _____
Date: _____

3) _____
Date: _____

4) _____
Date: _____

Primary Complaint: _____

Cause? _____

When did it start? _____

Have you had any imaging performed for this? ☐ Yes ☐ No

Type? ☐ X-ray ☐ Ultrasound ☐ C T ☐ MRI ☐ Other

Have you ever received treatment for this condition before? ☐Yes ☐No

How would you rate your current pain level? 1 2 3 4 5 6 7 8 9 10

If you have any additional information to provide, please state below:

_____

_____

487 Holland St. West, Unit L1, Bradford, Ontario L3Z 0C1 | T: 905-778-1888 | F: 905-778-1889

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Health Patient Consent

Use of Personal Information

RNS Health and Wellness Centre collects, uses, discloses, retains and disposes of your personal information in compliance with federal and provincial privacy legislation and applicable college regulations. All staff members who come in contact with your personal information have signed a confidentiality form and have been trained in the appropriate use and protection of your information. If you have any questions, please contact the us at 905-778-1888 or via email at reception@rnshwcentre.com. We use and disclose your personal information in the following ways:

- To assess your health concerns, advise you of options and provide healthcare
- To communicate with other treating healthcare providers, including your physician
- To obtain diagnostic test results pertinent to the condition for which you are seeking treatment
- To allow us to efficiently follow-up for treatment, care and billing via phone, email, addressed mail and voicemail
- To establish and maintain contact with you
- To complete claims for insurance purposes
- To communicate with insurance companies for attendance and billing purposes
- To invoice for goods and services and to collect unpaid accounts and process credit card payments
- To comply with the law
- To contact you from time to time during treatment and post-treatment about new services, changes to services, special offers, surveys, clinic updates and other opportunities, by phone, email or addressed mail and voicemail

Financial Responsibility

RNS will bill your insurance carrier on your behalf when we can verify that payment will be received by the clinic directly.
In the following circumstances, you will be responsible to pay at the time of service or product purchase:

- When you do not have any insurance that will cover the product or service
- When your insurance carrier sends payment directly to you or requires that you pay and submit your expenses
- When your coverage does not pay 100% or has been used up (you are responsible for the copayment)
- We are only able to bill your primary insurance plan. We are not able to do any co-ordination of benefits to secondary plans (eg: spouse or other parent's plan).
- When a product is custom ordered (deposit is required before ordering)
- All products are final sale

Consent for Assessment & Treatment

I give my consent to undergo assessment and treatment. I have had the chance to discuss with my healthcare provider(s) the risks and benefits for my condition. My treatment may include: manual therapy, modalities (e.g. heat, ice, wax, laser, ultrasound, interferential current (IFC), electrical muscle stimulation, TENS, mechanical traction, acupuncture, dry needling, intramuscular stimulation, spinal manipulation), and active exercise. I understand that results are not guaranteed and that I may withdraw this consent at any time. If deemed appropriate by my therapist, I agree to have a student or support personnel carry out my treatment plan under supervision. RNS may not be held accountable for any injuries I may incur as a result of the use of our rehabilitation equipment and exercise room facilities.

Cancellation Policy

We appreciate 24 hours notice for any cancellations and reserve the right to charge a cancellation fee ($40.00+HST) if not adhered to.

I authorize RNS Health and Wellness Centre to bill my treatments directly through Telus E-Health Portal, Greenshield, Bluecross Provider Portal, HCAI or WSIB e-billing if applicable. I understand that RNS will bill the insurance company after the service is provided.

I have read the above details and give my informed consent below.

Name of Patient (printed):	**Signature of Patient (or Guardian):**	**Date of Signature (mm/dd/yyyy)**
_____	_____	_____
Treating Practitioner (printed):	**Signature of Treating Practitioner:**	**Date of Signature (mm/dd/yyyy)**
_____	_____	_____