



# Highland PHYSIO

## COVID-19 Screening

Please fill out quick survey prior to your visit to help everyone stay safe and healthy.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

1. Have you travelled outside of Canada in the past 14 days? Yes  No
2. Have you tested positive for COVID-19 or had close contact with a confirmed case of COVID-19 without wearing appropriate PPE? Yes  No
3. Do you have any of the following symptoms?

<input type="checkbox"/> Decrease/loss of sense of taste or smell	<input type="checkbox"/> New onset of cough
<input type="checkbox"/> Worsening chronic cough	<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Difficulty breathing	<input type="checkbox"/> Sore throat
<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Headache
<input type="checkbox"/> Runny nose/nasal congestion with no known cause	<input type="checkbox"/> Pink eye
<input type="checkbox"/> Unexplained fatigue/malaise/muscle aches	<input type="checkbox"/> Chills
<input type="checkbox"/> Nausea/vomiting, diarrhea, abdominal pain	<input type="checkbox"/> Fever
4. If you are 70 years of age or older, do you have any of the following symptoms?

<input type="checkbox"/> Delirium
<input type="checkbox"/> Unexplained or increased number of falls
<input type="checkbox"/> Acute functional decline
<input type="checkbox"/> Worsening of chronic conditions

- ❖ If you have answered **NO** to all questions and do not exhibit any of the listed symptoms, then you may proceed with your appointment.
- ❖ If you have answered **YES** to any questions or any symptom then you may be asked to reschedule your appointment and further questioning may be required.

Signature: \_\_\_\_\_

By signing above, I certify all information is true and correct to the best of my knowledge.

**THANK YOU**

# HIGHLAND PHYSIOTHERAPY

## HEALTH CONSENT FORM (Massage Therapy)

*We need your informed consent. This means that we need you to understand the services we provide, the costs, and what we do with the personal information we gather about you. Please ask us if you have any questions.*

### CONSENT FOR THE COLLECTION OF PERSONAL INFORMATION

I understand that to provide me with physiotherapy or massage therapy and services, Highland Physiotherapy (herein known as the company) will collect some personal information about me. (e.g., name, address, phone numbers, and health history).

I have had the opportunity to review The Company's Privacy Policy about the collection, use, and disclosure of personal information, steps taken to protect the information and my right to review my personal information. I understand how the privacy policy applies to me. I have been given a chance to ask questions I have about the privacy policies and they have been answered to my satisfaction.

I understand that, as explained in the Policies and Procedures for Personal Information, there are some rare exceptions to these commitments.

I agree to The Company collecting, using, and disclosing personal information about me as set out above and in The Company's Privacy Policy.

### FEE SCHEDULE

Massage Therapy treatments in our clinic are NOT COVERED BY OHIP. Extended Health Insurance coverage for Massage Therapy is provided by various companies and we advise you to determine if you have such coverage (we will be happy to provide you with invoices so you can submit to your insurance company). If you are seeking Massage Therapy treatment as a result of a W.S.I.B. claim, or Motor Vehicle Accident, please advise us of such and we will initiate the appropriate billing.

However, please be advised that our contract is with you, the patient, and therefore you are ultimately responsible for payment of treatments rendered. This applies to all coverage methods (ie. Extended Health Care, W.S.I.B, and Motor Vehicle Insurance etc...). Please feel free to direct your questions to our staff. We will make every effort to assist you with your claim.

We accept Visa, MasterCard, American Express, Interac, Cheque or Cash.

<b>90 MINUTE MASSAGE</b>	<b>\$130.00</b>
<b>60 MINUTE MASSAGE</b>	<b>\$90.00</b>
<b>45 MINUTE MASSAGE</b>	<b>\$80.00</b>
<b>30 MINUTE MASSAGE</b>	<b>\$70.00</b>
<b>MISSED APPOINTMENTS or SHORT NOTICE CANCELS</b>	<b>\$40.00</b>
<b>CANCELLED APPOINTMENTS (with 24 HOUR NOTICE)</b>	<b>N/C</b>

See other side

## **Informed Consent to Massage Therapy Treatment**

I understand that the massage therapist is providing massage therapy services within their scope of practice as defined by the College of Massage Therapists of Ontario (CMTO).

I hereby consent for my therapist to treat me with massage therapy for the above noted purposes including such assessments, examinations, and techniques, which may be recommended, by my therapist.

I will discuss with my therapist any areas of my body that I am not comfortable with being treated.

I acknowledge that the therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that massage therapy is not a substitute for a medical examination. It is recommended that I attend my personal physician for any ailments that I may be experiencing. I acknowledge that no assurance or guarantee has been provided to me as the results of treatment. I acknowledge that with any treatment there can be risks and those risks have been explained to me and I assume those risks.

I acknowledge and understand that the therapist must be fully aware of my existing medical conditions. I completed my medical history form as provided by my therapist and disclosed to the therapist all of those medical conditions affecting me. It is my responsibility to keep the massage therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

I authorize my therapist to release or obtain information pertaining to my condition(s) and/or treatment to/from my other caregivers to third party payers.

I have read the above noted consent and I have had the opportunity to question the contents and my therapy. By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me and such additional treatment as proposed by my therapist from time to time to deal with my physical condition and for which I have sought treatment. I understand that at any time I may withdraw my consent and treatment will be stopped.

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

## Health History Form

The information request below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided will be kept confidentially unless allowed or required by law. Your written permission will be required to release any information.

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Email: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Occupation: \_\_\_\_\_

Have you received massage therapy before?  Yes  No

Did a health care practitioner refer you for massage therapy?  Yes  No

If yes, please provide their name and dress. \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Please indicate conditions you are experiencing or have experienced.

Cardiovascular	Respiratory	Infections	Head/Neck	Other
High blood pressure	Chronic cough	Hepatitis	Headaches	Loss of sensation
Low blood pressure	Shortness of breath	Skin conditions	Migraines	Diabetes
Chronic congestive heart failure	Bronchitis	TB	Vision problems	Allergies
Heart attack	Asthma	HIV	Vision loss	Epilepsy
Phlebitis/varicose veins	Emphysema	Herpes	Ear problems	Cancer
Stroke/CVA	Family history of above		Hearing loss	Arthritis or family history
Pacemaker or similar	Female			
Heart disease	Pregnancy			
Family history of above	Gynaecological conditions			

Please provide details (dates and specifics) on conditions listed above if necessary: \_\_\_\_\_

Do you have any other medical conditions? \_\_\_\_\_

Overall, how is your general health? \_\_\_\_\_

Current medications: \_\_\_\_\_

Are you currently receiving treatment from another health care professional?  Yes  No

If yes, for what and who? \_\_\_\_\_

Surgeries (date and nature): \_\_\_\_\_

Injuries (date and nature): \_\_\_\_\_

Internal pins, wires, artificial joints or special equipment? \_\_\_\_\_

Why are you seeking massage therapy? \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Office Use Only:** Date of Initial Health History: \_\_\_\_\_ Update 1: \_\_\_\_\_

Update 2: \_\_\_\_\_ Update 3: \_\_\_\_\_ Update 4: \_\_\_\_\_