WHAT TO BRING TO YOUR FIRST VISIT

- **SPINEgroup Intake Forms & Outcome Measures**

- **Medication/Vitamin List / Drug Allergies**

Make a list of any medications and vitamins you are currently taking including dosages and frequency. Include a list of any drug allergies you may have.

- **Motor Vehicle Insurance Information**

Please bring your insurance company information, including the claim number, policy number and adjuster name and contact information. Bring any correspondence from your insurance company. Briefly describe and illustrate details of your accident, i.e. intersection, speed, size of vehicle, # of passengers.

- **Workers Compensation (WSIB) Information**

Bring the claim number, adjuster name and contact information and any correspondence from WSIB.

- **Doctor Referral**

If your insurance company requires a physician's referral for massage therapy, physiotherapy or for assistive devices such as orthotics or compression stockings please bring the referral to the clinic.

- **X-rays, MRI Scan, CT Scan, Other Studies**

Please make certain you bring any x-rays, MRI scans, CT scans, etc., as well as any radiology reports. Bring all studies that have been done within 6 months or related to your injury or condition.

CLINIC POLICIES

Our policies are designed to promote quality care and maintain optimal relationships with patients.

Information and Record Keeping

SPINEgroup is responsible for the privacy of all patient data and information. We will not disclose any medical information to any third party (except as may be required by other health professionals involved with your care or as required by law) without written consent from the patient. No medical information about you may be given over the phone, including laboratory or diagnostic results.

Cancellations or Missed Appointments

SPINEgroup enforces a strict cancellation policy to ensure sufficient time for patient services is provided each day. We require a 48 hour (2 day) notice during regular office hours for any appointment cancellation. This ensures that we have adequate time to fill the time slot for another patient. A fee will be charged to your account for all missed appointments without the required notice period. Cancellations for emergency circumstances will be considered if you reschedule your appointment at your earliest convenience.

Financial Policy

All services rendered are paid for at the time of service unless an alternative arrangement has been made with clinical director. Medical services: patients must provide a valid (non-expired) OHIP card at every visit. In the event of an expired card, patients will be billed directly for services. We provide all patients with receipts of payment for submission to insurance companies but cannot bill directly to 3rd party coverage insurers (with the exception of WSIB and Motor Vehicle Insurers.) Payment options include cash, debit or Visa. Please call for cost of initial examination.

PHONE: (905) 850-SPINE | FAX: (905) 850-1871 www.spinegroup.ca

Patient Intake Form:

Patient Full Name_____Age_____ o Male o Female

Date of Birth: D_____/M_____/Y_____ Marital Status: S M W D Sep

OHIP #_____Version Code_____

Street Address_____City_____Province_____

Postal Code _____ Home Phone Number (_____) _____ Cell # (_____)_____

Work Number (_____)_____ Email Address_____

How did you hear about us? o Phone Book Sign Physician Referral Friend o Website o Other_____

Employer_____Occupation_____

Patient's Family Doctor_____Phone # (_____)_____

Name of Spouse or Parent (if minor)_____

Is this a work-related injury? o Yes o No Is this a motor vehicle accident Injury? o Yes o No

Motor Vehicle Insurance Company: _____
MVA/WSIB Information:

Claim #_____Policy # _____

Case Manager/Adjuster Name:_____ Contact Number (_____)_____

Date of Accident: D_____/M_____/Y_____

Policy Holder's Name_____Relationship to Patient _____

Legal Representative: _____ o Lawyer is Not Involved
Phone: (_____)_____ Fax: (_____)_____

Do you have Extended Health Coverage? o Yes o No Do you have secondary coverage? o Yes o No

Primary Extended Health Insurance Company: ____

_____ Policy #_____

_____Employee ID# _____ Policy Holder's Name_____

_____Relationship to Patient _____

Policy Holder's Date of Birth: D_____/M _/Y_____

AUTHORIZATION TO RELEASE INFORMATION, ASSIGNMENT OF BENEFITS, REFUND & CANCELLATION POLICY

I hereby consent and authorize payments of WSIB, personal injury, extended health insurance and MVA insurance claim benefits to Dr. Connie D'Astolfo Chiropractic Professional Corporation ("SPINEgroup™") for all health services, rendered or to be rendered in the future, without obtaining my signature on each such claim. I also authorize the release of any medical information by Spinegroup to others necessary as required for treatment, billing purposes and medical research and/or clinical educational purposes. I UNDERSTAND I AM PERSONALLY RESPONSIBLE AND LIABLE FOR ALL CHARGES. If this account should be referred to a collection agency, I will be PERSONALLY responsible for any collection and reasonable legal fees, interest and costs.

SPINEgroup enforces a strict cancellation policy to ensure sufficient time for patient services is provided each day. We require a 48 hour (2 day) notice during regular office hours for any appointment cancellation. This ensures that we have adequate time to fill the time slot for another patient. A fee will be charged to your account for all missed appointments without the required notice period. There are no refunds for supplements, clinical services and prepaid services, assessments and programs.
I HAVE READ AND UNDERSTOOD THE POLICIES AND PROCEDURES.

X_____Date_____

Patient/Parent/Guardian Signature

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SPINEgroup

INFORMED CONSENT & PERMISSION TO DISCLOSE HEALTH INFORMATION

I. We are seeking **Informed Consent** for the health services we provide including: chiropractic, private physiotherapy, publicly-funded physiotherapy, massage therapy, podiatry, nursing, dietary, psychological, naturopathic, medical, and/or acupuncture services. Your treating health provider(s) within your "circle of care" are authorized to share your **Personal Health Information** ("PHI") for the purpose of collaborative management of your care. We always use all reasonable efforts to ensure privacy when entering your PHI in our common e-health record or EMR system such that your PHI information is not misunderstood, misused or lost by any health provider who may have access to your electronic patient chart.

II. Requests for services will begin with an initial clinical assessment. Feedback will be provided with suggestions given as to the course of treatment in terms of type, provider, length, plan and general approach. Referrals to other professionals outside the clinic may be made. Any changes in the type of treatment service to be provided in the future will be discussed with you in advance.

III. Only pre-sterilized needles are used. All acupuncture needles are properly disposed of after each and every treatment.

IV. There are risks and possible risks associated with orthopedic evaluation, functional assessments, acupuncture, manual therapy, mechanical traction, use of rehabilitation equipment and rehabilitation conducted by doctors of chiropractic, physiotherapists, acupuncturists, massage therapists or registered nurses. In particular, you should note:

a) While rare, some patients may experience aggravation of symptoms or muscle and ligament strains or sprains, bruising or irritation as a result of manual therapy, injection therapy, shockwave therapy, rehabilitation, acupuncture or in rare circumstances; orthopedic or functional evaluation. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures, including spinal manipulation.
b) I understand and am informed that in the practice of acupuncture there are some risks to treatment, including, but not limited to, minor bleeding, or bruising, minor pain or soreness, nausea, fainting, infection, shock, convulsions, possible perforation of internal organs, and stuck or bent needles.
c) Recent studies, etc. suggest that patients may be consulting medical doctors, nurses, physiotherapists, and chiropractors when they are in the early stages of a stroke (a stroke already in progress). You are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with cervical manipulation is extremely remote and occurs infrequently. Please inform your treating provider immediately if you experience any unusual neurological symptoms, severe head, jaw and/or neck pain.
d) There are rare reported cases of disc or spinal injuries identified following cervical and lumbar spinal manipulation, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal manipulation. In some circumstances, manual therapy/spinal manipulation may aggravate an already existing degenerative disc condition.
e) There are infrequent reported cases of burns or skin irritation in association with the use of some types of ultrasound, electrical therapy, shockwave and laser therapy.

V. There are possible risks associated with assessments or counseling (nursing, chiropractic, occupational, vocational or psychological) including, the rousing of upsetting feelings. You are encouraged to advise your health provider if these should arise.

VI. There are risks associated with rehabilitation and the use of rehabilitation or exercise equipment at the facility. Risks include but not limited to muscle/ligament straining and falls, even under supervision. Vestibular and stability training through the use of therapy balls, rocker boards, vibration therapy, etc. pose a risk for falls thus proper footwear and padded environment must be maintained. The clinic provides rubber flooring in the rehab area and mats for protection. The patient assumes risk of injury when undergoing rehabilitation/exercise therapy.

VII. Disclosure of Personal Health Information: *Confidentiality and Privacy is respected at all times.* Sessions with all healthcare providers at SPINEgroup® and the information discussed are **confidential**; that is, the contents of a session, or even whether or not you attend, will not be revealed to outside sources unless you have given written consent/permission to do so, or as required by law. You maintain the right to review your PHI and patient file (which will be held in a secure location for a minimum of 10 years, after the last date of contact or 10 years after a patient's 18th birthday). Exceptions to confidentiality include the legal and/or ethical obligations to report as follows:

a) Inform a potential victim of violence of a client's intention to harm (if you are in, or appear to be in imminent danger of doing serious harm to yourself or another person);

b) Inform an appropriate family member, health care professional or police if necessary of a client's intention to end his or her life;
c) If there is reasonable suspicion based on your report that you or anyone else (under the age of 16) may be or have been a victim of physical, sexual and/or emotional abused by anyone, the appropriate children's aid society will be informed;
d) Report a health professional who has sexually abused a client/patient;
e) Release of a client/patient file if there is a court order or summons court attendance and/or for a production of your records;
f) As part of ongoing consultation, training, education, billing or research our providers may discuss or present the particulars of your case with other health professionals or insurers related to your treatment plan. With respect to publishable research and educational purposes, any information that would enable one to identify you will be de-identified. Statutory Accident Benefit claims require disclosure of health information (resulting from the motor vehicle accident as well as pre-existing conditions) to insurers, health professionals and social workers involved in your claim. Finally, professional Colleges conduct random Quality Assurance and it is possible that patient files will be disclosed to them if they initiate this process or a similar process.

VIII. Payment Policy: Payment for assessments and therapy is normally expected at each session (Cash, VISA, MASTERCARD, Debit, etc.) unless an alternate arrangement has been made with Clinical Director (with the exception of WSIB and Motor Vehicle Insurance Claims). In this way, the account remains manageable and your therapy becomes a naturally budgeted expense. Receipts will be given when payment is received. Please retain these receipts for your insurance or income tax claims, if applicable. SPINEgroup does not guarantee supplements, orthotics, braces, or any assistive mobility device.

IX. Cancellation Policy: Payment is expected for any missed session, unless the appointment is cancelled **at least forty-eight (48) business hours** in advance. If you arrive more than twenty (20) minutes late for an appointment, you will be charged the full session fee. In accordance with the professional fees and billing practices, overdue accounts will be charged interest rates of 1.5% monthly. If payment becomes a concern, please discuss it with the clinical director or clinic manager to avoid service charges for late payment or more active efforts to secure overdue statements.

SIGNED CONSENT

□ **I consent to disclosure of my PHI to treating health providers at SPINEgroup who are involved in my care. Your signature indicates you have reviewed our *Informed Consent & Permission to Disclose Health Information* form about the potential risks of assessments, treatments and rehabilitation; the collection, use and disclosure of personal information, steps taken to protect the information and your right to review your personal information. You understand that, as explained herein, there are some rare exceptions to these commitments.**

□ **I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my health provider the nature and purpose of my treatment in general, benefits and risk of treatment, alternate treatment options and recommendations for my condition, payment and cancellation policies and all the contents of this Consent. I have been given a chance to ask any questions about assessment and treatment risks and they have been answered to my satisfaction. I consent to the interdisciplinary treatment recommended to me by my provider including any recommended assessments, evaluations, rehabilitation, physical medicine, manual therapy, medical or naturopathic services and counseling services provided by any of the clinicians at SPINEgroup as listed in Section I**.

→ Email Address:_____[optional]

□ I further agree to receive SPINEgroup's newsletters containing news, updates and health promotions regarding SPINEgroup's health services and products. You can later withdraw your consent at any time by sending an email to admin@spinegroup.ca

□ I also intend this Informed Consent to apply to all my present and future care at SPINEgroup.

Date

_____ _____

Patient Signature (Legal Guardian) **Witness/Signature**

Print Name:_____ **Print Name:** _____

7611 Pine Valley Drive, Unit 1
Vaughan, Ontario, L4L 0A2

Tel: (905) 850-7746 Fax: (905) 850-1871 Email: admin@spinegroup.ca

Authorization and Direction to Release Clinical Records

To: _____

And To: _____

From [**Patient's Full Name**]: _____

YOU are hereby authorized and directed to forward a copy of my entire Medical and/or Health Records requested herein by [**Clinical Provider Name(s)**]:

_____,

whose full address is set out above in *italics*, AND YOU are also you are also hereby authorized and directed to communicate with my Clinical Provider(s) as required for the duration of my care at the health facility, AND THIS shall be your good and sufficient full authority to do so.

Date: _____

Patient Signature: _____

Requested Medical and/or Health Records [**Please print clearly**]:
Date /___/___: _____
Date /___/___: _____
Date /___/___: _____
Date /___/___: _____
Date /___/___: _____
Date /___/___: _____
Date /___/___: _____
Date /___/___: _____
Date /___/___: _____
Date /___/___: _____

Patient Consent to Release Personal Health Information:

Ontario Publically Funded Physiotherapy

I consent to the Ministry of Health collecting the following personal health information about me or the patient for whom I act as a Substitute Decision Maker (as applicable) from the Clinic for the verification purposes listed above:

1. the patient's name
2. the patient's date of birth
3. the patient's Ontario Health Insurance Plan number
4. the patient's clinical record including details of their assessment, diagnosis, treatment plan and discharge
5. the dates on which the Clinic provided Services to the patient

Signature: **check one** √

☐ I am signing for myself.

☐ I am signing on behalf of _____ as a parent, or person who
[insert name of patient]
Is lawfully entitled to give or refuse consent, on behalf of a child who is under 16.

☐ I am signing as a Substitute Decision Maker for a person who does not have capacity. I assert that I am _____'s
[insert name of patient]

_____.
[state appropriate description of the Substitute Decision Maker from the ranked list above, e.g. guardian of the person, attorney for personal care, spouse]

I understand that I can withdraw my consent by contacting **SPINEgroup®** at **(905) 850-7746** and that if I withdraw my consent, I **will be required to pay the Clinic directly for services that the Clinic provides to me as a patient following the withdrawal of consent**.

Name: _____
[please print]

Signature: _____ Date: _____
[(YYYY-MM-DD]

Telephone number: _____
[if you are signing on behalf of a child or as a Substitute Decision Maker for a person who does not have capacity]

If you have questions about this consent form, please contact: **SPINEgroup®** at 1-7611 Pine Valley Drive, Vaughan ON, L4L 0A2 – Telephone: (905) 850-7746 – Email: admin@spinegroup.ca

Patient Consent to Release Personal Health Information

The Ministry of Health (the "Ministry") pays for the physiotherapy services (the "Services") **SPINEgroup®** (the "Clinic") provides to you. The Ministry conducts periodic reviews to verify the Services the Clinic provided to you and to ensure the proper use of public funds.

Your Personal Health Information

To enable the Ministry to conduct its review, the Ministry needs to collect the following personal health information from the Clinic:

1. your name
2. your date of birth
3. your Ontario Health Insurance Plan number
4. your clinical record including details of your assessment, diagnosis, treatment plan and discharge
5. the dates on which the Clinic provided Services to you

Consent for Verification Purposes

The Clinic is, therefore, asking you for your consent to allow the Ministry to collect your personal health information to assist the Ministry with its review.

Who can sign the consent form?

You can sign the consent form if:
- you are a patient of the Clinic; **or**
- you are a patient's "Substitute Decision Maker" authorized under *Personal Health Information Protection Act*, 2004. (See more information about what this means, below).

What does "Substitute Decision Maker" mean and who is authorized under the Personal Health Information Protection Act, 2004 to act as the patient's Substitute Decision Maker?

If a patient does not have capacity[i] to give, withhold or withdraw consent, a Substitute Decision Maker can give, withhold or withdraw consent to the collection, use and disclosure of the patient's personal health information on behalf of the patient.

You can act as a Substitute Decision Maker for a person who does not have capacity if you have capacity and you are the highest ranked person in this list:

- a substitute decision-maker within the meaning of the Health Care Consent Act, if the collection, use or disclosure of information is connected to the decision of a substitute decision-maker about the patient's treatment;
- the guardian of the person;
- the attorney for personal care;
- the representative appointed by the Consent and Capacity Board;
- the spouse or partner;
- a child, a parent, a children's aid society or other person who is allowed by law to give or refuse consent in the place of the parent;
- a parent who has a right of access to the child;
- a sibling;
- a relative; or

• the Public Guardian and Trustee, if no other person meets the requirements.

Who can consent if the patient is under 16 years of age?

1. **The child**, so long as the child has capacity to consent,
2. **A parent of the child** (including a child with capacity), a member of the children's aid society, or another person who is legally able to consent in the place of the parent except for certain situations noted below.

A child under the age of 16 who consented to their own treatment, must decide whether to consent to the collection, use or disclosure of their personal health information related to that treatment. If a child under the age of 16 has capacity to consent and disagrees with the decision of their parent (or the person legally able to consent in place of the parent), the child's decision overrides the decision of their parent (or the person legally able to consent in place of the parent).

For clarity, there are two situations in which the parent (or other legally authorized person) cannot give consent:

1. If the personal health information relates to a treatment that a child consented to (or refused to consent);
2. If the child is capable of consenting and makes a decision about their personal health information that conflicts with the parent, or other legally authorized person's decision.

When your consent will be effective

If you give your consent to this collection by the Ministry - either as a patient, or as Substitute Decision Maker for a patient - your consent will be effective as of the date on which you sign the consent form below.

If you choose not to consent

If you choose not to consent to this collection by the Ministry:

1. the Ministry will not pay the Clinic for the Services the Clinic provides to you or the person on whose behalf you are acting as a Substitute Decision Maker; and
2. **you will be required to pay the Clinic directly for the Services**.

You may withdraw your consent

If you provide your consent now you may decide to withdraw it later, but please note your withdrawal will only apply going forward and will not have any retroactive effect.

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[i] Capacity in this context means that you are able to understand the following: (1) the information on the form that explains why the Ministry wants to collect the personal health information and what they will do with that information; and (2) the consequences of giving or withholding consent.