



Escarpment Sports Medicine Centre

MVA PATIENT INTAKE

PERSONAL INFORMATION			
Last Name		First Name	
Address		Email (for appointment reminders)	
City	Province	Postal Code	
Date of Birth (ddmmyy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Home phone #	Cell phone#
Family Physician			
Phone #		Fax #	

WORK INFORMATION		
Employer		Occupation
Address		
City	Province	Postal Code
Telephone #		Fax #

INSURANCE		
EXTENDED HEALTH INSURANCE INFORMATION		
Do YOU or YOUR SPOUSE or PARENT have Work Extended Health Coverage?		
Insurance Company Name	Plan/Policy #	Group/ID #
Telephone #	Fax #	
Policy Holder's Name	Policy Holder's Date of Birth (ddmmyy)	
AUTOMOBILE INSURANCE INFORMATION		
Insurance Company Name	City or Town of Branch Office	
Adjuster's Name	Telephone #	Fax #
Date of Loss (ddmmyy)	Policy #	Claim #
Name of policy holder same as: <input type="checkbox"/> Applicant	Policy Holder's Name OR	

LEGAL INFORMATION		
Law firm	Legal Representative	
Address	Telephone #	Fax #



Physiotherapy Consent for Assessment and Treatment

Physiotherapy is a form of rehabilitation that incorporates various modalities of pain relief, manual therapy and functional conditioning that target an individual's ultimate goal to return to or exceed his/her pre-injury function.

Before beginning treatment I acknowledge that the therapist needs to do an assessment. I understand that the assessment may aggravate my symptoms but it is necessary for the physiotherapist to find the origin(s) of my pain(s).

Patient signature

Date

Physiotherapy treatment consists of modalities, manual therapy, supervised exercise program and education. Mechanical modalities include interferential current (IFC), muscle stimulation (NMES), transcutaneous electric nerve stimulation (TENS), ultrasound, acupuncture, heat therapy and cold therapy. The physiotherapist will always screen each patient to ensure the appropriate use of any modality.

Manual therapy may include mobilization, stretching, muscle energy release techniques, massage and traction. There is also an inherent risk of aggravation of symptoms and discomfort during the treatment session. However, these methods have been shown in the literature to be useful and beneficial to an individual's recovery when deemed appropriate by the physiotherapist. All manual therapy will be performed and monitored only by the physiotherapist.

An active exercise component is always incorporated into a treatment plan with the goal of conditioning an individual back into their activities of daily living and/or sport. With this component of treatment comes the risk of muscle soreness, strain or aggravation of symptoms. However, the exercise program will be tailored to suit the needs and limitations of the individual and will be monitored by the physiotherapist and/or auxiliary staff. Pain and injury will weaken an individual's general physical state and therefore the exercise program is paramount to recovery. Each individual will be screened for the appropriateness of each exercise prescribed.

I, _____, have read the above information and understand the risks and benefits of having physiotherapy treatment and have agreed to proceed with the rehabilitation program as prescribed by my physiotherapist. Finally, I am aware that I have the right to refuse any treatment that I still feel is inappropriate for me after having been explained the risks and benefits.

Patient signature

Therapist Signature



INTRODUCTION TO REHABILITATION - MVA

Welcome to Escarpment Sports Medicine Centre. Our facility is greater Halton's most comprehensive Orthopaedic & Sports Physiotherapy organization. Our clinic provides access to a fellowship trained primary care Sports Medicine Specialist, an Orthopaedic Surgeon, as well as excellence in Orthopaedic and Sports Medicine Physiotherapy and Rehabilitation.

In an effort to guide you through your rehab process we have outlined a few important details that you should keep in mind:

1. Once you have reported your auto insurance company, a claim will be set up under your name. You will have two adjusters handling your file – one to handle the property damage claim and one who will handle your health claim. The adjuster handling your health claim is called your accident benefits or AB adjuster. Please provide us with your AB adjuster's name and contact information.
2. Your AB adjuster will mail you an accident benefits package. This package needs to be completed and returned within 30 days. This package includes the following: OCF-1 for you to complete, OCF-2 for your employer to complete, OCF-3 for your doctor to complete and an OCF-23 or OCF-18 for your therapist to complete. ***It is your responsibility to follow up and ensure that these forms have been completed and sent in to your auto insurance company.*** An incomplete package can ultimately result in the auto insurance company denying your claim.
3. In terms of payment, by law we are required to submit all invoices first to your extended health carrier(s). This includes coverage you may have through your work and/or your spouse's work. We will ask you to complete the appropriate claim forms and we will submit the invoice to the extended health company on your behalf. They will however mail the cheque and the statement of benefits to you. It is imperative that you bring in BOTH the cheque AND the attached statement as soon as you receive it. We will then submit the balance of the invoice to the auto insurance company. Your auto insurance company will not pay the invoice until they receive proof that the invoice was submitted to the extended health company. ***Please remember that your account is ultimately your responsibility.***
4. Please note that in the rare circumstance that you fail to turn over the extended health payments to our facility, your account may be deemed "delinquent" and we may be forced to submit your account to a collections agency.

If you have any further questions regarding your entitlement to physiotherapy as it pertains to your motor vehicle accident please feel free to speak to any of our front desk staff or to your therapist.

I hereby acknowledge having read the information listed above and agree to the terms and conditions as outlined.

Patient Name: _____

Patient Signature: _____

Date: _____



ESMC Cancellation Policy

Our cancellation policy enables us to better utilize available appointments for our patients in need of treatment.

If you need to cancel your appointment please call us at (905) 864-9945 at least 24 hours in advance.

Any cancellations with less than 24 hours notice (exceptions apply) may result in a \$25 charge to your account with us.

If you do not show up for an appointment and fail to notify us, a \$25 charge will be applied to your account.

I have read and understand the above.

Client's signature

Date

Witness