MONTEBELLO Physiotherapy
& Sport Rehabilitation

118 Lake St, St Catharines, ON, L2R 5Y1 info@montebellophysio.com

Client Information Sheet **Date:**_____

Personal Information

Patient Name: Last name: _____ First: _____

Address:_____

_____

City Province Postal Code

Telephone: Home:(___)_____ Work: (___)_____

Cell: (___)_____ Email: _____

Date of Birth (D/M/Y): _____

Occupation: _____

Physicians Information

Physician`s Name:_____ Telephone: (___)_____

Address:_____

_____

Diagnosis	**Please Circle all types of Billing**
Area of Injury:	Private Client YES
	Extended Health Care YES _____
_____	Motor Vehicle Accident YES signature

Motor Vehicle Accident

Claim Number: _____ Date of Accident (D/M/Y): _____

Insurance Company: _____

Have you lost days of work: YES NO Are you on modified duties: YES NO

Claim Adjuster Last name: _____ First: _____

Telephone: (___)_____ext_____

Extended Health Benefits: for MVA claims approval, you must disclosed all extended health benefits

□ NO □ YES (please provide details for)

Insurer 1: Insurer Name:_____ Plan or Policy Name:_____

Plan Member Name: _____ (Last) _____(First)

Insurer 2: Insurer Name:_____ Plan or Policy Name:_____

Plan Member Name: _____ (Last) _____(First)

Referral? How did you hear about Montebello Physiotherapy? _____

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All treatments provided by a registered physiotherapist.
Josh Droppert PT, BSc Kin, MPT
Caitlin Pauls PT, BScHs, MSc PT
Jaya Sam PT, BScMS, MSc PT

Treatment Cost

- Professional services provided are not covered by O.H.I.P., all bills are to be paid after each treatment.
- As per Ontario law all treatment costs will first be billed to private health insurance and the remaining balance to the auto insurance company; however, it is up to the patient to continually inform the clinic with any changes in their claim.
- Your treatment will include some or all of the following depending on your specific condition; education, mobilization, manipulation, acupuncture, massage, passive and active stretching, or my official release. Please do not hesitate to ask any questions regarding your treatment. Any complication or side effects will be discussed with you as deemed necessary or required.

We respect your treatment and set individual appointment times, in return we ask for a minimum of 4 HOURS notice to cancel an appointment or you will be charged a $30.00 fee. Initial _____

Patient Consent

- I agree and consent to a physiotherapy assessment and treatment by a registered physiotherapist. I have read and understand the polices above and agree to stand by these conditions. I additionally provide consent for my physiotherapist to communicate with and release information to other health practitioners who are involved in my treatment program.
- I understand that all my medical records will remain confidential by my physiotherapist and will not be released without my written consent to anyone other than those mentioned above, except where required by law.

Initial _____

Privacy Act

- Starting January 1, 2004 physiotherapist require signed consent to collect, utilize, and disclose any personal information for each patient.
- Your information is required for the following:
    - To set up the most appropriate treatment for your health condition.
    - To consult with other health practitioners involved in your treatment.
    - To help our office communicate with you regarding your treatment.
    - To collect payment for your account.
    - To comply with the regulatory requirements of the Ontario College of Physiotherapist.
- We understand it is important to protect your personal information and therefore have procedures in place to protect your information.
- If your personal information is required for any reason not mention above, we will require your signed consent prior to any disclosure.
- You may choose to withdraw your consent at any time by submitting your request in writing.

I have reviewed all the above information and understand how my personal information will be used by this office. I further understand that this office is taking steps to protect my personal information.

_____	_____	_____	_____
Name (print)	**Signature**	**Date**	**Signature of Witness**