Alpine Physiotherapy & Massage

New Patient Intake Form

Premium Assistance/First Nations: MSP partially covers the visit if you are on premium assistance or have registered First Nation status. MSP will partially cover 10 combined annual visits per calendar year. These visits are combined with physiotherapy, massage therapy, chiropractor, naturopathy, and non-surgical podiatry. There is a $20.00 user fee for each initial visit and a $15.00 user fee for each follow up visit that must be paid by the patient. When all 10 visits are used, you will be charged the private fee.

Private Patients: Private patients are charged a fee of $80.00 for an initial visit (new patient, new injury/area, or have not been treated for three months or more) and $65.00 for each follow up visit. We are set up for direct billing to some extended health care plans (please ask to see if your plan is one that we can direct bill to). Some or all your fee may be covered by your extended health plan. You will be responsible for any fee not covered by your plan, or for the entire amount should you not have extended benefits. You will be issued a receipt for any amount you must pay to the clinic.

***Please note that we will not issue copies of you receipts.**

WorkSafe BC patients: you must have a referral from your doctor. WorkSafe BC will pay for your initial treatment providing your claim is "pending" and your physiotherapy session is within 60 days of the date of your injury. Approval from WCB is required for any further treatments. If you attend physiotherapy while your claim is pending, you will be responsible for any payments incurred that WCB will not pay for.

ICBC patients: ICBC will cover the full amount of Physiotherapy treatments if you have been approved by them. If you attend without pre-approval, you will be responsible for any payments incurred that ICBC will not pay for.

IMS/Acupuncture/Extended visits: Private patients will pay $80.00 for each IMS/Acupuncture or extended visit. Premium assistance/First Nations patients will pay a $20.00 user fee for each of these treatments.

Informed consent: I understand that the physiotherapist provides a wide range of services, and I will receive information at my initial visit concerning the treatment and options available for my condition.

We require **24 hours' notice** for any cancellations, otherwise there is a $30.00 missed appointment fee incurred. ***Any missed appointment fees incurred MUST be paid in full prior to re-scheduling an appointment.***

I have read, understood, and agree to the above information.

Signature of patient/guardian: ______________________________ Date: ______________________________

Witness: ________________________________

PATIENT INTAKE FORM

Patient name: _____________________________________ Date of Birth: ______________________________

Mailing Address: __________________________________ City: _______________ Postal code: ____________

Home phone: _____________________ Work phone: _______________ Cell phone: _____________________

Email address: ____

May we contact you via email? YES NO

BC Care Card #: ____________________________________

Extended medical provider: ______________________________

Policy #: _____________________________ ID#: ___________________________________

Family Doctor: ____________________________ Specialist Doctor: ___________________________________

Employer: _____________________________________ Occupation: __________________________________

Emergency contact: ____________________________ Phone #: ______________________________________

Relationship: _______________________

Is this a WCB or ICBC claim: ___________ if yes, Claim #: _____________________ DOI: __________________

What is the main problem/reason for attending Physiotherapy? _______________________________________

____

When did the problem start? _______________________________

Have you had any x-rays/CT scans/investigations for your current problem? If so, when: ________________

____

Previous injuries/complaints? ____

____

Have you, or are you, receiving any other treatments for the current complaint or related condition?

____

Have you had any previous or recent Surgery? If so, please detail.

____

____

Do you have any pre-existing medical conditions?

____

Please list all medications you are currently taking.

____

____

Please list any allergies you have.

____

Please list any sports/hobbies/recreational activities.

____

Please indicate any of the following conditions that apply to you both currently and or previously.

Any heart condition		Cancer	
High blood pressure		Epilepsy/seizures/blackouts	
High cholesterol		Vascular disease	
Diabetes		Are pregnant	
Have a pacemaker		HIV positive	
Hepatitis		Rheumatological conditions	
Osteoporosis		Bleeding disorder	
Congenital disorder		Respiratory disease	
Stroke/TIA		Taking any blood thinners	

Electronic Transmission Authorization and Consent Form

Instructions: This form must be filled out when claims are submitted electronically by the provider on the patient's behalf. Please retain this form in the patient's file for verification purposes for two years following closure of the patient file.

Insurance Provider: ______________________________
Address:_______________________________________
City/Province:___________________________________
Postal Code:____________________________________
Phone Number:__________________________________

Patient: _______________________________________
Address:_______________________________________
City/Province:___________________________________
Postal Code:____________________________________
Phone Number: __________________________________
Plan Number: ____________________________________
Certificate / Plan member Number: ___________________

Consent to Collect and Exchange Personal Information

Message to the Plan member, Spouse and/or Dependent regarding Personal Information

Personal information that we collect and disclose about you, and if applicable, your spouse and/or dependents, is used by the insurer and/or plan administrator and their service provider(s) for the purposes of assessing your claims, underwriting, investigating, auditing, and administering the group benefits plan, including the investigation of fraud and / or plan abuse.

Authorization and Consent

I authorize my healthcare provider to collect, use and disclose personal information concerning any claims submitted on my behalf with the insurer and/or plan administrator and their service provider(s) for the above purposes.
I authorize the insurer and / or plan administrator and their service provider(s) to:

- use my personal information for the above purposes.
- exchange personal information with any individual or organization, including healthcare professionals, investigative agencies, insurers and reinsurers, and administrators of government benefits or other benefits programs when relevant for the above purposes.
- exchange personal information concerning any claims submitted with the plan member or a person acting on behalf of the plan member.
- exchange personal information for the above purposes electronically or in any other manner.

I understand that personal information may be subject to disclosure to those authorized under applicable law.
I agree that a photocopy or electronic version of this authorization shall be as valid as the original and may remain in effect for the continued administration of the group benefits plan.

Electronic Transmission Authorization and Consent Form

Additional Consent Applicable to Plan Members Only

I confirm that I am authorized by my spouse and/or dependents, if any, to disclose personal information about them to the insurer and/or plan administrator and their service provider(s) for the purposes described above and I confirm that my spouse and/or dependents also authorize the insurer and/or plan administrator and their service provider(s) to disclose information about their claims to me, for the purposes of assessing and paying a benefit, if any, and managing the group benefits plan. I also authorize my spouse and/or dependents to assign benefit payments under the plan to the healthcare provider.

In the event there is suspicion and/or evidence of fraud and/or plan abuse concerning claims submitted, I acknowledge and agree that the insurer and/or plan administrator and their service provider(s) may use and disclose relevant personal information to any relevant organization including law enforcement bodies, regulatory bodies, government organizations, medical suppliers and other insurers, and where applicable my Plan Sponsor, for the purposes of investigation and prevention of fraud and/or plan abuse.

If there is an overpayment, I authorize the recovery of the full amount of the overpayment from any amount payable under the group benefits plan, and the exchange of personal information with other persons or organizations, including credit agencies and, where applicable, my Plan Sponsor, for that purpose.

Date: _________________________ Signature: ______________________________

Print Name: ______________________________

Benefit Assignment Form

Instructions: This form must be filled out when claim payment is assigned to the Provider. Please retain this form in the patient's file for verification purposes for two years following closure of the patient file.

Insurance Provider: ____
Address:____
City/Province: _____________________________________
Postal Code: ______________________________________
Phone Number: ____________________________________

Patient: ____
Address: ____
City/Province: ______________________________________
Postal Code: ____
Phone Number: ______________________________________
Plan Number: _______________________________________
Certificate / Plan member Number: ____________________

I hereby assign benefits payable for the eligible claims to the Provider responsible for submitting my claims electronically to the group benefits plan and I authorize the insurer/plan administrator to issue payment directly to the Provider. In the event my claim(s) are declined by the insurer/plan administrator, I understand that I remain responsible for payment to the Provider for any services rendered and/ or supplies provided.

I acknowledge and agree that the insurer/plan administrator is under no obligation to accept this Assignment, that any benefit payment made in accordance with this Assignment will discharge the insurer/plan administrator of its obligations with respect to that benefit payment, and that in the event the benefit payment is made to me, the insurer/plan administrator will also be discharged of its obligation with respect to that benefit payment.

I understand that this Assignment will apply to all eligible claims submitted electronically by the Provider and that I may revoke it at any time by providing written notice to the insurer/plan administrator.

If I am a spouse or dependent, I confirm that I am authorized by the plan member to execute an assignment of benefit payments to the Provider.

Date: ___________________________ Signature: _______________________________

Print Name: ______________________________