Total Therapy Rehabilitation & Wellness Centre

North Burnaby
4162 Dawson St, Burnaby
Phone 604.437.9355 Fax 604.437.9356
Email: NorthBby@TotalTherapy.ca

Metrotown
4665 Central Blvd, Burnaby
Phone 604.620.9700 Fax 604.620.9771
Email: Metro@TotalTherapy.ca

North Vancouver
702-1150 Marine Dr, North Vancouver
Phone 604.971.5212 Fax 604.357.1300
Email: NorthVan@TotalTherapy.ca

CONFIDENTIAL PATIENT INFORMATION

Please fill out **ALL** of the following information, print legibly in **CAPITAL** letters, and
ENSURE THAT YOUR NAME IS EXACTLY AS IT APPEARS ON YOUR CARE CARD:

Last Name: _____ **First Name:** _____ **Middle Initial:** _____

Street Address: _____ **City:** _____

Postal Code: _____ **E-mail:** _____

Home Phone: _____ Work: _____ Cell: _____

Care Card #: _____ **Date of Birth:** _____ _____ _____ **Gender** F / M
dd mm yy Non-Binary

Do you have MSP Premium Assistance? Y / N

Physician (Full Name): _____ **Phone:** _____

Occupation: _____ **Employer:** _____

Are you currently, or do you plan on, pursuing a claim with ICBC or WCB for your injuries Y / N

Insurer*: ICBC / WCB / RCMP *A Doctor's referral is required for all ICBC and WCB patients. **Claim / Identification #:** _____

Adjuster: _____ **Date of Injury:** _____

Phone #: _____ **Fax #:** _____

Have you received treatment for your injury prior to attending Total Therapy? Y / N

How did you hear about Total Therapy?

Physician – Integrated Wellness
→ Name of Physician: _____

Physician – Other
→ Name of Physician: _____

Health/Rehab Clinic
→ Name/Therapist: _____

Total Therapy Metrotown
→ Who Referred You? _____

Total Therapy North Burnaby
→ Who Referred You? _____

Total Therapy North Vancouver
→ Who Referred You? _____

Social Media
→ Blog:___ Facebook:___ Twitter ___ YouTube:___

Internet Search
→ What did you search for? _____
→ What did you click after your search?
_____

Spouse
→ Name of Spouse: _____

Family
→ Name of Family Member: _____

Friend
→ Name of Friend: _____

Work Colleague
→ Name of Colleague: _____

Mail Advertisement
→ What Type? _____

Posters / Brochures etc.
→ Where did you see us? _____

Walk/Drive by
→ What caught your eye? _____

Advertisements
→ What Type? _____

E-Newsletter
→ Specify Date: _____

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Please indicate if any of the following apply to you:
(P = Past C = Current)

___ Heart Attack	___ Headaches / Migraines	___ Joint Dislocation
___ High / Low Blood Pressure	___ Dizziness / Fainting	___ Joint Reconstruction
___ Stroke or Aneurysm	___ Nausea	___ Bone Fracture
___ Pace Maker	___ Spinal Injury	___ Arthritis
___ other Heart condition	___ Head Injury	___ Osteoporosis
___ Varicose Veins	___ Epilepsy / other seizures	___ Implants
___ Bruise Easily	___ other Neurological condition	___ Transplants
___ other Circulatory condition	___ Irritable Bowel / Colitis	___ Skin condition
___ Diabetes	___ Digestive condition	___ Contagious condition
___ Kidney Disease	___ Asthma	___ Cancer
___ other Urinary condition	___ Chronic Sinusitis	___ Hepatitis
___ **are you pregnant?**	___ other Respiratory condition	___ HIV

Recent treatment: (P = Past C = Current, does not have to be related to this visit)

___ Physiotherapy ___ Massage Therapy ___ Chiropractor ___ Naturopath ___ Other (_____)

Please list any Medications you presently take: _____

_____

Known Allergies (including medications, foods, seasonal, oils and lotions, latex, etc.):

_____

Past surgeries, illnesses, accidents / relevant medical history: _____

_____

Fee Policy

I understand that I am responsible for any payment of treatment(s) provided, and to pursue coverage for treatment(s) with insurers. I will receive a receipt for services rendered, and I am responsible for arranging reimbursement by my insurer (including MSP/ICBC/WCB) if such an arrangement is warranted.

Late Cancellations & Missed Appointments

In consideration of other clients and your therapist, please allow at least 24 HOURS NOTICE to change or cancel appointments. You will be CHARGED A FEE for late cancellations or missed appointments. Thank you.

_____ _____ _____

Signature **Date** **Witness**

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AUTHORIZATION FOR RELEASE OF PERSONAL INFORMATION; CONSENT TO TREATMENT AND USE OF FACILITIES

TO: TOTAL THERAPY and their directors, officers, agents, representatives, employees, volunteers, independent contractors, subcontractors, successors and assigns (collectively, "Total Therapy").

How We Share Information

Communication is key to safe and effective care. We may need to communicate with your physician or other members of your healthcare team. We will also contact you regarding your appointments and clinic information.

I give permission for Total Therapy to communicate with other healthcare providers, Total Therapy staff, and third parties involved in my care. I authorize Total Therapy to contact me about my appointments, promotions, and clinic updates. I understand that my personal information is confidential and that Total Therapy will take the utmost care to safeguard my privacy. (A full copy of our privacy policy is available upon request).

Treatment at Total Therapy

As with all forms of therapy, there are benefits and risks involved. The physical response to a specific treatment varies from person to person, so it's not always possible to predict your response to a certain therapeutic modality or procedure. We are not able to guarantee precisely what your reaction to treatment might be, nor can we guarantee that our treatment will help the condition you are seeking treatment for.

There is also a risk that your treatment may cause pain or injury, or may aggravate previously existing conditions. You have the right to ask your therapist what type of treatment he or she is planning based on your history, diagnosis, symptoms, and personal goals. You may also discuss with your therapist what the potential risks and benefits of a specific treatment might be. Some potential risks may include:

- Health: strains, sprains, pain; overexertion; dehydration; fatigue.
- Premises: falls; collisions with objects, equipment or other people.
- Use of Equipment: mechanical failure of the equipment; negligent design or manufacture of the equipment; failure to use or operate the equipment correctly or within my own ability.
- My conduct and conduct of other persons: may increase the risk of damage, loss or personal injury and/or property.

You can decline any portion of your treatment at any time. It is important that you maintain an open and honest dialogue with your therapist, so he or she can adjust your treatment as needed.

By signing, I have read the information above and have had my questions answered to my satisfaction. I understand that treatment has risks associated with it, some of which may not be foreseeable. I understand that if rehabilitation and/or wellness services are being provided outside of the clinic, I may receive modified assessment and treatment due to the nature of the event at which it is provided. I understand that I can decline treatment at any time, and I agree to be open and honest with my therapist about my condition. I choose to pursue treatment at Total Therapy, and waive any potential claim or liability against Total Therapy that may result from my treatment and/or participation in services, except in the case of gross negligence on the part of Total Therapy.

Signature: _____ Date:_____

Please Print Name: _____ Witness:_____