IRELAND MANUAL PHYSIOTHERAPY

New Client Initial Intake Form

Personal Information			
Last Name	First Name	Middle Initial	Date of Birth (Y/M/D)
Home Address: Number and Street			Apartment Number
City	Province		Postal Code
Email	Primary Phone		Alternate Phone
Emergency Contact	Relationship		Phone
Email Consent: By initialing, I consent to Ireland Manual Physiotherapy sending emails related to exercises, clinic information, appointments, and basic correspondence.			***Client initials***:_____

Referral		
Family Doctor/Nurse Practitioner	Referring Physician (same as FD/NP ☐)	Other
Why are you seeking physiotherapy treatment?		

How did you hear about Ireland Manual Physiotherapy?				
☐ Website	☐ Flyer/Newspaper	☐ Returning	☐ Events	☐ Family/Friend
☐ Social Media	☐ Doctor	☐ Store Front	☐ Video Ad	☐Google
Other:				
Why did you choose Ireland Manual Physiotherapy?				

Cost of Physiotherapy Services (fee schedule differs for WSIB and MVA):	
Initial Assessment: $120.00 Typical Follow-up Appointment: $74.00 Initial Pelvic Health Assessment: $130.00 Follow-up Pelvic Health Appointment: $95.00 Complex Ortho or Re-Assessment: $95.00	If you do not cancel or reschedule your appointment with at least **24 hours notice**, the full appointment fee will be applied to your account. This charge is not reimbursable by your insurance company and you will be billed directly for it. ***Client initials*** agreeing to fees and cancellation policy: _____

Coverage Type			
☐ **No coverage**	☐ **Extended health (Section A)**	☐ **MVA (Section A and B)**	☐ **WSIB (Section C)**

Section A: Extended Health Benefits Information (for secondary plan, please complete *Secondary Insurance Section*):			
Name of Insurance Company	Name of Policy Holder (☐ Self)		Policy Holder's Relationship to Client
Policy Holder DOB (Y/M/D)	Policy/Claim Number	ID/Certificate Number	Name of Employer
☐ I request that Ireland Manual Physiotherapy (IMP) directly bill my extended health benefits (EHB) for services rendered. **I understand that I am responsible for any amounts unpaid by my EHB**. ***Client initials***:_____			
I authorize IMP to release any pertinent personal health information to my physician(s). I also consent to the treatment plan, release of information, communication from IMP via phone &/or e-mail, and I recognize that I may withdraw consent for any aspect of treatment at any time. ***Client Signature***:_____ **Date:**_____			
Secondary Extended Health Benefits (if applicable)			

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☐ I understand that depending on the coordination of benefits with my primary coverage, Ireland Manual Physiotherapy **may not be able to direct bill on my behalf to my secondary health benefits**. I understand that I am responsible for the balance owing after submission to my primary benefits in the event Ireland Manual Physiotherapy cannot bill this directly on my behalf. ***Client initials:***_____

Name of Insurance Company	Name of Policy Holder (☐ Self)	Policy Holder Date of Birth (Y/M/D)
Policy Holder's Relationship to Patient	Policy/Claim Number	ID/Certificate Number

Section B: Motor Vehicle Accident Insurance Information (Section A must be completed if you have private insurance)

Name of Insurance Company	Name of Policy Holder (☐ Self)	Policy Holder Date of Birth (Y/M/D)
Policy Holder's Relationship to Patient	Policy Number	Claim Number
Date of Accident (Y/M/D)	Name of MVA Adjuster	Adjuster Phone
Adjuster Fax	Adjuster Email	Address of Insurance Company

Have you completed the paperwork sent by your insurance (**OCF 1: Application for Accident Benefits**)? ☐ Yes ☐ No

Government issued identification verified by Ireland Manual Physiotherapy staff? ☐Yes Staff initials:_____

I authorize Ireland Manual Physiotherapy (IMP) to release any pertinent personal health information to my physician(s) and my auto insurance company. I give my consent for the treatment plan and release of information, communication from IMP via phone&/or e-mail and recognize that I may withdraw consent for any aspect of treatment at any time.

Client Signature:_____ **Date:**_____

Section C: Workplace Injury Information (if applicable)

Date of Injury (Y/M/D)	**Claim Number**	Name of Employer
Employer Contact and Position	Employer Phone	**Employer Fax**
Address of Employer	Job title at time of injury	Length of time in position

Are you currently working? ☐Yes: Duties: ☐Regular ☐ Modified Hours: ☐ Regular ☐ Modified	☐No: How long do you think you will be off?

Name of Case Manager	Phone	Fax

Have **you** completed the initial paperwork when reporting the injury at work (**Form 6**)? ☐ Yes ☐ No

Has your **workplace** completed their paperwork and submitted it to WSIB (**Form 7**)? ☐ Yes ☐ No ☐ Unknown

Has your **doctor** (or another healthcare provider) completed any paperwork (**Form 8**)? ☐ Yes ☐ No ☐ Unknown

I authorize Ireland Manual Physiotherapy (IMP) to release any pertinent personal information to my physician(s), my employer & WSIB. I authorize IMP to provide my employer with information regarding my functional abilities, as stated on the Form 8, POC assessment form, FAF, or other related forms. I understand a copy of the form(s) will be sent to WSIB. I give my consent for the treatment plan, release of information, communication from IMP via phone &/or e-mail & recognize that I may withdraw consent for any aspect of these physiotherapy services at any time.

Client Signature:_____ **Date:**_____