ADVANTAGE
SPORT MEDICINE
PHYSIOTHERAPY

Consent Form

PHYSIOTHERAPY/ATHLETIC THERAPY CONSENT TO TREATMENT

I hereby consent to the assessment and treatment performed by the Registered Physiotherapist/Certified Athletic Therapist named below.

I understand that treatment may include treatments for therapeutic, preventative, diagnostic, or other health related issues.

I understand that I may revoke or amend this consent in writing.

I have read the above consent, and I have had the opportunity to ask questions about its content. This consent will cover the physiotherapy/athletic therapy assessment and entire course of treatment.

_____ _____

Patient's Name (Please Print) Physiotherapist's/Athletic Therapist's Name

_____ _____

Date Signature of Patient

How did you hear about Advantage Sport Medicine?

Family Physician ☐ HealthPointe Physician ☐ Family / Friend ☐

Google/Internet ☐ Social Media ☐

Other: _____

To receive email correspondence from our clinic, please provide your email address here:

_____

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PLEASE FILL OUT THIS FORM TO GIVE ADVANTAGE CONSENT TO DIRECT BILL YOUR HEALTH INSURANCE

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.

Provider: Advantage Sport Medicine

Address: Suite 302, 575 100 St SW

City/Province: Edmonton, AB

Postal Code: T6X 0S8

Phone Number: (780) 229 - 0174

Patient: _____

Date of Birth: _____

Address: _____

City/Province: _____

Postal Code: _____

Phone Number: _____

Plan Number: _____

Group Number: _____

Member ID Number: _____

OFFICE USE ONLY

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	Print Name	Signature

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***PLEASE FILL OUT THIS FORM TO GIVE ADVANTAGE**
CONSENT TO DIRECT BILL YOUR HEALTH INSURANCE*

Electronic Transmission Authorization and Consent Form 1

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.

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

1) 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.
2) I authorize the insurer and / or plan administrator and their service provider(s) to:
   a. use my personal information for the above purposes.
   b. 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.
   c. exchange personal information concerning any claims submitted with the plan member or a person acting on behalf of the plan member.
   d. exchange personal information for the above purposes electronically or in any other manner.
3) I understand that personal information may be subject to disclosure to those authorized under applicable law.
4) 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.

_____	_____	_____
Date	Print Name	Signature

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.

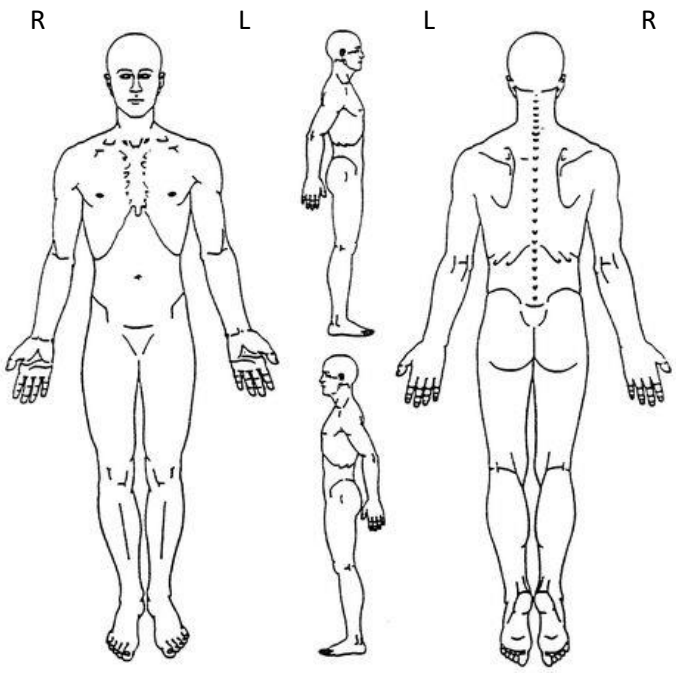
In the event there is suspicion and/or evidence of fraud and/or plan abuse concerning claims submitted, I acknowledge and agree that the insurer and/or plan administrator and their service provider(s) may use and disclose relevant personal information to any relevant organization including law enforcement 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	Print Name	Signature

Health Screen

Pain Diagram – Please indicate area of pain or discomfort on the diagram below.



When did your pain start?

_____

_____

What caused your pain to start?

_____

_____

Do you have a history of other injuries or pain? Yes No

_____

Do you have a history of surgical procedures? Yes No

_____

Have you received any previous treatment for this injury? Yes No

_____

Have you had any diagnostic imaging done on this injury? Yes No

_____

Any additional comments:

_____

_____

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Health Screen

Indicate if you have ever been diagnosed with any of the following health conditions:					
	Yes	**No**		**Yes**	**No**
Stroke			Osteoarthritis		
Diabetes			Rheumatoid Arthritis		
Epilepsy			Other Inflammatory Arthritis		
Osteoporosis			Depression/Anxiety		
Thyroid Dysfunction			Kidney Disease		
Cancer			Fibromyalgia/Chronic Pain Syndrome		
Tuberculosis			Heart Disease/Coronary Artery Disease		
High Blood Pressure			Other Heart Condition		
Asthma			COPD		
Pacemaker			Metal Pins, Plates, or Screws in Bone?		
Any other conditions not listed:					
Indicate if you have experienced any of the following symptoms:					
Chest Pain			Difficulty Breathing at Rest		
Nausea			Bowel Dysfunction		
Persistent Cough			Bladder Problems (ie leaking when you cough)		
Seizures			Dizziness or Fainting		
Blood Clots			Swelling in Legs or Feet		
Circulation Problems			Significant Weight Gain or Loss		

Please list any medications you are currently taking:	
Please list any allergies:	

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PATIENT DEMOGRAPHICS

In a continuous effort to maintain accurate and up-to-date contact information on our patients, we would ask that you take a moment to fill out the form below. Should your personal information change at any time we would greatly appreciate you contacting our office to advise us.

First Name:_____ **Last Name:**_____

Mailing address: _____

City: _____ **Province:** _____ **Postal Code:** _____

Home #: _____ **Work #:** _____ **Cell #:** _____

Personal Health Care #: _____ **Date of Birth (dd/mm/yyyy):** _____

How would you like to be reminded of appointments?
(Please enter the phone number or email address)

Text ☐ _____ Local Number Only _____
OR
Email ☐ _____

FAMILY DOCTOR: _____ First & Last Name _____ **How did you hear about our clinic:** _____

EMERGENCY CONTACT:_____ **PH #:**_____

Are you presently taking any of the following **blood thinners**? **Y __ N __**

- ☐ Warfarin
- ☐ Coumadin
- ☐ Plavix
- ☐ Baby Aspirin
- ☐ Other

Do you have a pace maker? **Yes** **No**

Are you Diabetic? **Yes** **No**

List all allergies:

ONLY COMPLETE THIS BOX IF THIS IS AN OPEN WCB CASE – NOT PENDING, CLOSED OR IN APPEAL

Is this an open **WORKER'S COMPENSATION** claim? **YES ____ NO_____** **WCB claim#**

Date of Injury **Body Part** _____

If you wish to allow a family member or another source to be able to contact our office regarding some of your information such as appointments, please list them below.

_____ _____
Family Member *Other (please specify)*

By my signature below, I give consent for Advantage Sport Medicine & Physiotherapy to disclose information to the above mentioned. I understand that I may withdraw my consent at any time providing reasonable written notice to the clinic I am attending.

_____ _____
Signature Date