Male Pelvic Floor Physiotherapy Intake Form:

Name:_____
Last First Middle Initial

Date of Birth:_____ Age:____ Sex:____ Height:_____ Weight:_____
yyyy/mm/dd

Address:_____ City_____ Postal Code:_____

Telephone: (home)_____ (work)_____ (cell)_____

Email Address _____

Family Physician:_____

How did you find out about Fit 4 Life?_____

Employer:_____ Occupation:_____

Fit 4 Life Wellness Centre requires 24 hours notice for cancellation or you may be charged a cancellation fee. I, the undersigned, acknowledge and understand Fit 4 Life Wellness Centre's cancellation policy.

_____(initial)

Please be advised, Pelvic Floor Physiotherapy is an internal treatment

Consent for treatment:

Date_____

Signature of Patient OR Parent/Guardian if under 18 _____

Medical History

Referring Physician:_____

Diagnosis:_____

Have you ever received Physiotherapy for this problem? And if so when?

_____

Have you ever received other treatment for this problem? (Chiropractic? Medications? Etc.)

Medical History:

Please circle all that apply:

Heart problems	High Blood Pressure	Low Blood Pressure
Seizures	Cancer	Thyroid Dysfunction
Recent Fracture(s)	Asthma	COPD
Chronic Bronchitis	Rheumatoid Arthritis	Osteoarthritis
Osteoporosis	Smoker	Kidney Problems
Diabetes Type 1 or 2	Stroke	DVT
Neuromuscular Disorder	Autoimmune Disorder	Preeclampsia
Anxiety	Depression	High Cholesterol
Erectile Dysfunction	Premature Ejaculation	Urinary Tract Infections

Other/Explanation:_____
_____
_____

Have you had any of the following medical procedures? Please Circle

Appendectomy
Hernia Repair
Vasectomy
Hemorrhoid banding
Prostatectomy
Cystoscopy
Urodynamics
Gallbladder Removal
Bowel Resection
Colostomy
Other_____

Current Medications:_____

Allergies:_____

Occupation:_____

At work do you sit / stand / walk /other? _____

Bladder Symptoms:

Do you have pelvic pain? If so when did it begin? _____

What causes your pain/when do you notice it the most?
_____
_____
_____

Rate you pain on a scale of 0-10, 0 is no pain and 10 being the worst imaginable: _____

Do you suffer loss of urine control (incontinence)? Y N

If yes, please circle those that apply: laughing /sneezing / coughing / physical activity

Other/Explanation:_____
_____
_____

What of your normal activities are affected by your symptoms?
_____

Please list your goals for Physiotherapy:

WE CAN DIRECT BILL TO **MOST** INSURANCE COMPANIES! PLEASE CONTINUE TO PAGE 4 FOR YOUR INSURANCE INFORMATION AND DIRECT BILLING CONSENT

Fit 4 Life Wellness Centre will direct bill to MPI, WCB, Manitoba Blue Cross, Medavie Blue Cross (RCMP, DVA, National Blue Cross), Great West Life, Chambers of Commerce, CINUP, First Canadian, Johnston Group, Cowan, Industrial Alliance, Desjardins, Manulife, Maximum Benefit, Johnson Inc., Sunlife, Green Shield, SSQ *Please note that **some individual plans do not allow direct billing***

Billing Information and Consent to Direct Bill

Insurance Company_____

Plan/Policy/Contract/ Certificate #_____ ID/Group#_____

MPI/WCB Claim Number_____ RCMP#_____

Percent % Covered_____ Yearly Maximum_____ Plan Deductible_____

Policy Holder: Name_____ DOB_____

Dr.'s Referral Required? (please circle) Yes / No, If yes:

Please provide a copy to Fit 4 Life Wellness Centre Inc. Otherwise, we cannot direct bill on your behalf

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 services provider(s) for the purpose 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 administer 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 reinsurer, and administrators of government benefits or other benefit 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 a plan member.
- Exchange personal information for the above purposes electronically or in any other manner
- Direct payment from my insurance provider to Fit 4 Life Wellness Centre Inc. for the service I have received

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.

I hereby give Fit 4 Life Wellness Centre Inc. authorization and consent to direct bill to the private insurance company I have provided to them and agree to all terms and conditions included in the direct billing process as stated above which includes Fit 4 Life Wellness Centre Inc. receiving all payments reimbursed to them from my private insurance company for the services they have provided to me.

Attention: All individual private insurance plans are different. Any fees not paid by the insurance provider is responsibility of the undersigned. Payment is required at the time of treatment. It is the responsibility of the patient to be aware of their insurance coverage, plan deductible and plan maximums. Should the insurance provider pay less than anticipated, or not at all for the treatment provided, the undersigned will be invoiced all outstanding fees and must pay at the time of the invoice.

DATE_____ SIGNATURE_____

"Take care of your body and it will take care of you!" –F4L