



Pediatric Physiotherapy Intake Form:

Name: _____
Last First Middle Initial

Parent/Guardian: _____
Last First

Address: _____ City _____ Postal Code: _____

Childs Date of Birth: _____ Age: _____ Gender: _____
yyyy mm dd

Height: _____ Weight : _____

Guardian Telephone: Primary _____ (Other) _____

Guardian Email Address: _____

Family Physician Name and Medical Centre: _____

What is the reason for your child's appointment today? _____

***How did you find out about Fit 4 Life*:**

- Doctor _____
(please let us know which Doctor)
- Driving by/ I live in the area
- East/West St. Paul Magazine
- Facebook
- Friend or Family member

(please let us know who!)
- Google
- Instagram

- Pamphlet
- Sign Advertisement
- Fit 4 Life Staff Member

(please let us know which one!)
- Website
- Word of Mouth
- Other _____
(please explain)

Past Medical History:

Please list any diagnoses, surgeries, hearing and/or vision impairments, and hospitalizations below:

Please list your child's current motor milestones he/she has achieved: (For example, crawling, cruising, supported sitting):

Please list your goals for Physiotherapy: (For example, achieve walking milestone, improve crawling pattern, reduce pain with movement):

Fit 4 Life Wellness Centre requires 24 hour's 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)**

Consent for treatment: Please sign below for treatment consent for your child

Signature of Parent/Guardian: _____

WE CAN DIRECT BILL TO **MOST** INSURANCE COMPANYS! PLEASE CONTINUE TO PAGE 3 FOR YOUR INSURANCE INFORMATION AND DIRECT BILLING CONSENT

Fit 4 Life Wellness Centre can direct bill to **MOST** insurance companies. Please ask us if your plan is one of them!

Billing Information and Consent to Direct Bill

Insurance Company _____

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

MPI Claim Number _____

Percent % Covered _____ Yearly Maximum _____ Plan Deductible _____

Policy Holder: Name _____ DOB (Y/M/D) _____

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 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 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 _____

DIRECT BILLING PATIENT AGREEMENT

Fit 4 Life Wellness Centre is pleased to be able to submit claims to insurance providers on behalf of our patients. In order for us to be able to continue to offer this service it is crucial that our patients understand the following:

1. We do not have access to your insurance information. Most insurance companies do not provide us with any plan details.

_____ (Initial)

2. If you do not know your specific plan information (including but not limited to: percentage covered, yearly plan deductible, per visit maximums, yearly maximums etc.), then we cannot keep track of that information for you. We will submit your claim on your behalf, but you must be prepared to pay any outstanding balances.

_____ (Initial)

3. Any fees not paid by your insurance provider become your responsibility. If your insurance company does not pay for your treatment for any reason, the entire fee, or the portion not paid by your insurance provider becomes your responsibility. Payment is due at the time of the invoice.

_____ (Initial)

4. We may not get an immediate response from your insurance provider advising us of what they will pay for your treatment. Therefore, we may contact you after your appointment letting you know that you have an outstanding balance owing once we receive an official payment statement from your insurance company.

_____ (Initial)

5. We advise all patients to contact their insurance company to ensure our services provided to you will be covered under your plan. **We do not hold any responsibility for any denial of service claims from your insurance provider.**

_____ (Initial)

6. Insurance companies may issue payment to the plan member in error which is common. It is considered fraudulent to keep a payment from your insurance provider for a service you received but did not pay for. We kindly request that if the payment was sent to you, that you forward it to Fit 4 Life as soon as possible.

_____ (Initial)

7. Claims to insurance providers are submitted as soon as possible. It is not guaranteed that we are able to submit every claim at the time of service.

_____ (Initial)

I hereby acknowledge the above information and understand that the entire fee of the service provided is ultimately my responsibility. I understand that Fit 4 Life Wellness Centre is submitting claims for my treatment on my behalf and I will take full responsibility for any fees not paid by my insurance provider. I understand that the amount paid by my insurance provider may not be determined until Fit 4 Life receives an official payment statement from my insurance provider, and at such time, I will be contacted by Fit 4 Life Wellness Centre and provided with an invoice showing the outstanding balance and I understand payment is due at the time of the invoice. If I do not agree to the direct billing terms stated above, I will pay for my service in full at the time of my treatment and submit the claims to my insurance provider. At any time, Fit 4 Life can refuse to direct bill on my behalf for any reason.

DATE _____ SIGNATURE _____