Physiotherapy and Massage Therapy Intake Form:

Name:____
Last First Middle Initial

Date of Birth: ______________________ Sex: ____ Height: _____ Weight: ______
yyyy mm dd

Address:___________________________________ City_________________ Postal Code:__________________

Telephone: Primary_______________________________ Other_____________________________________

Email Address ____
(appointment reminders)

Family Physician:____

Employer:_____________________________________ Occupation:____________________________________

Injury/ area of body to be treated____

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)

Continue to page 2!

Medical History:

Please check off the following that apply to you, if Yes please explain on lines provided:

	Yes	No
Osteoarthritis	___	___
Rheumatoid Arthritis	___	___
Osteoporosis	___	___
Scoliosis	___	___
Neuromuscular Disorders	___	___
Stroke	___	___
Heart Attack	___	___
Angina	___	___
Epilepsy	___	___
Anxiety or Depression	___	___
Pacemaker	___	___
High Blood Pressure	___	___
Low Blood Pressure	___	___
Breathing Disorders (Asthma, COPD, etc)	___	___
Diabetes	___	___
Thyroid Condition	___	___
Skin Conditions	___	___
Auto immune conditions	___	___
Cancer	___	___
Dizziness/Vertigo	___	___
Previous Surgeries	___	___

Explanation:____
____
____
____

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)

Physiotherapy/ Massage Therapy Consent for treatment:

Signature of **Patient** OR (Parent/Guardian if under 18) ____

WE CAN DIRECT BILL TO **MOST** INSURANCE COMPANYS! PLEASE CONTINUE TO PAGE **3** TO PROVIDE 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#__________________________

Percent % Covered____________ Yearly Maximum____________ Plan Deductible__________

Policy Holder: Name_______________________________________ DOB_________________

Does your plan require a doctors referral? (please circle) Yes / No, If yes: We must have a copy on file to submit your claim

Payment information to be kept on file:

Credit Card Number: Expiry date: 3 digit verification number:

For us to keep track of your remaining coverage, you must provide us with an **accurate yearly maximum** OR if you have used some of your coverage this year, **an accurate remaining balance**. If you don't know this information, please contact your insurance provider. **Any fees not covered by your insurance company become your responsibility.**

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____

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____