Clover Hills Rehabilitation
#112 - 18438 64th Ave Surrey, BC, V3S 1E9
Tel: 778-574-7722
www.cloverhillsrehabilitation.com

NEW PATIENT INTAKE FORM

Date: _____

Full Name: _____ **Gender:** **Male**☐ **Female**☐

Birthdate (MM/DD/YY): _____ **Age:** _____ **Marital Status:** _____

Address: _____
(Street) **(City)** **(Postal Code)**

Cell #:_____ **Home #:**_____ **Email:**_____

Employer: _____ **Occupation:** _____

Emergency Contact: _____ **#:** _____**Relationship:**_____

Appointment Reminder (you may choose more than one): ☐**Email** ☐**Text** ☐**Phone Call**

How did you hear about our clinic? _____

Care Card #: _____ (Office Only): MSP Coverage ☐ _____

☐ **Extended Health Insurer:** _____ ☐ **Self** ☐ **Spouse** ☐ **Parent**
Extended Health Policy #: _____**Member ID:** _____

☐ **ICBC Claim#:** _____ **Adjuster:** _____ **Lawyer:** _____

☐ **WCB Claim#:** _____ **Adjuster:** _____

Previous Treatment: Physiotherapy:☐Y☐N **Chiropractic**☐Y☐N **Massage:**☐Y☐N **Acupuncture:**☐Y☐N

Name of Medical Doctor: _____

Permission to contact your medical doctor for lab results? :☐Y☐N
If Yes, Please sign: (Patient Signature)_____

Please complete the next page →

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ASSIGNMENT OF PAYMENT

I hereby appoint the therapists from whom I receive treatment from at Clover Hills Rehabilitation, as my attorney for the limited purposes of:

1. Requesting and receiving benefits, (as defined in the Medical Care Services Act), which benefits were provided to me by one or more therapists, and for which I as "beneficiary" under the Act, am entitled to reimbursement pursuant to section 8 (1) Act.

2. Depositing any cheque issued in respect of such benefits, in any financial Institution, to the credit of Clover Hills Rehabilitation Inc.

I further acknowledge that if the cost of my treatment(s) is not met by the insuring company, ie. MSP, WCB, or ICBC, I am responsible for any outstanding fee(s), including the user fee and the opt-out fee, for any treatments received.

CANCELLATION POLICY

Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in the therapists' day that could have been filled by another patient. As such, we require **24 hours** notice for any cancellations or changes to your appointment. Patients who provide less than 24 hours notice, or miss their appointment, will be charged a cancellation fee. Please call our office to cancel or change your appointments.

PRIVACY AND SHARING OF INFORMATION

I authorize the clinic and its associated health professionals to collect my personal and medical information as documented on my new patient intake form. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor and permission to contact me via email regarding home care exercises/stretches as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

I acknowledge that I have read, understood and agreed to the information mentioned above.

_____	_____	_____
Name (print)	**Patient Signature (Legal Guardian)**	**Date**

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INFORMED CONSENT

It is important for you to consider the benefits, risks and alternatives to the treatment options offered by your health care professionals at Clover Hills Rehabilitation and to make an informed decision about proceeding with treatment.

Benefits: Physiotherapy, chiropractic care, acupuncture, massage therapy treatment has been demonstrated to be effective for complaints of the neck, back and other areas of the body caused by nerves, muscles, joints and related tissues. Treatment by your health care practitioner can relieve pain, including, altered sensation, muscle stiffness and spasm. It can also increase mobility, improve function, and reduce or eliminate the need for drugs or surgery.

Risks: The risks associated with physiotherapy, chiropractic care, acupuncture and massage therapy treatment vary according to each patient's condition as well as the location and type of treatment. The risks include:

a) Temporary worsening of symptoms: Usually, any increase in pre-existing symptoms of pain or stiffness will last only a few hours to a few days.

b) Skin irritation or burn: Skin irritation or a burn may occur in association with the use of some types of electrical or light therapy. Skin irritation should resolve quickly. A burn may leave a permanent scar.

c) Sprain or strain: Typically, a muscle or ligament sprain or strain will resolve itself within a few days or weeks with some rest, protection of the area affected and other minor care.

d) Rib fractures: Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures.

e) Stroke: There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke. Recent studies suggest that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote.

Please complete the next page →

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Risks Continued:
f) Disc injuries: There are rare reported cases of disc injuries identified following cervical and lumbar chiropractic adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or other chiropractic treatment.

Alternatives: Alternatives to treatment may include consulting other health professionals. Your health care professional may also prescribe rest without treatment, or exercise with or without treatment.

Questions or Concerns: You are encouraged to ask questions at any time regarding your assessment and treatment. Bring any concerns you have to your health care professional. If you are not comfortable, you may stop treatment at any time.

Please be involved in and responsible for your care. Inform your health care professional immediately of any change in your condition.

I acknowledge that I have read, understood and consent to treatment at Clover Hills Rehabilitation. I intend this consent to apply to all my present and future care by the health professionals at Clover Hills Rehabilitation.

_____	_____	_____
Name (print)	**Patient Signature (Legal Guardian)**	**Date**

_____	_____	_____
Witness Name (print)	**Witness Signature**	**Date**