

5109-50th Ave., Wetaskiwin, AB T9A 0S5 Phone: (780) 312-2899

5010- 50th Ave., Leduc, AB T9E 6T3 Phone: (780) 980-2877

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: home( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ work ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Postal Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ cell ( )­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth: (M/D/Y) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Would you like to receive our newsletter via e-mail? YES / NO (circle one)

How did you hear about our clinic? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency contact name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this injury work related? YES / NO

Is the injury a result of a motor vehicle accident? YES / NO

**Health History**

Have you had any recent surgeries? If yes, please explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any recent major injuries (broken bones, muscle sprains, strains, tears, etc.):

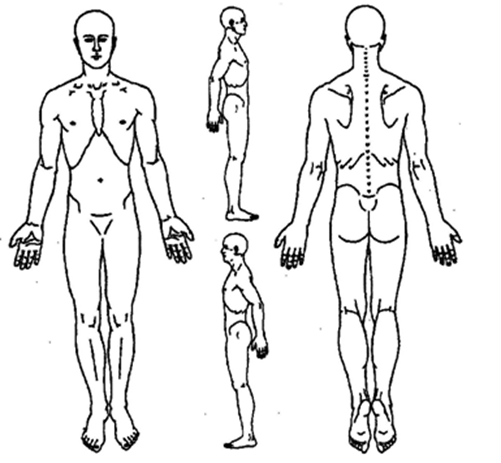
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any allergies that you have to Medication, Herbs, Food or anything else: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any medications you are currently taking:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please indicate all areas of pain on the diagram below:**



Please rate your currently level of pain: \_\_ Severe \_\_ High \_\_ Moderate \_\_ Low

Rate your current level of stress? \_\_ Severe \_\_ High \_\_ Moderate \_\_ Low

**Do you now have or ever had any of the following conditions? (please check)**

* Headaches
* Back Pain
* Numbness
* Osteoporosis
* High/low Blood Pressure
* Arthritis
* Diabetes
* Dizziness
* Asthma
* Heart Disease
* Stroke
* Cancer
* Kidney Disease
* Lymphatic condition
* Blood Clots
* Multiple Sclerosis
* Cerebral Palsy
* Chronic Fatigue Syndrome

**Payment Agreement for Services**

Our office policy states that payment must be made in full, and I agree to pay in full for all services performed at Refresh Wellness Centre at the time of service, payable to the Therapist providing my care, unless other arrangements have been made at the time of service.

If your account is not paid in full within 30 days, you will be responsible for any expenses incurred in the collection process of your account. If you are involved in any type of litigation case i.e.: auto accident and you choose to discontinue care before the doctor releases you, your balance will be due, immediately.

Third Party Direct Billing: I authorize payment of medical benefits to the Registered Massage Therapist from which I have received treatment for services rendered. In the event we are unable to direct bill your insurance provider a receipt will be provided for you to submit in your own time.

I understand that I am financially responsible to pay Refresh Wellness Centre for all insurance checks that are sent to me from my insurance company for services rendered in this office that were meant for services completed by the treating Therapist. In the event reimbursement monies are sent to me instead of the treating practitioner, or should the claim submitted on my behalf be denied I understand I am responsible for payment on my account immediately for all services completed**. \_\_\_\_\_ (Patient initials)**

**Cancellation and Missed Appointment Policy**

Refresh Wellness Centre requires appointment cancellations be received in advance of 24hrs of a scheduled appointment. Any cancellations received within 24 hrs of a scheduled appointment time will result in a cancellation fee of **$50** charged to your account and payable at your next visit. **\_\_\_\_\_ (Patient initials)**

Any missed appointments (no shows) will be charged a missed fee at the **full fee** for the appointment missed. This fee is payable at your next visit. **\_\_\_\_\_\_ (Patient initials)**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, agree to abide by the above policies.

Patient/ Legal Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reviewed with Patient (practitioner initial): \_\_\_\_\_\_\_\_\_\_**

**Informed Consent for Massage Therapy**

I hereby consent for the Registered Massage Therapists at Refresh Wellness Centre to treat me with massage therapy including assessments, stretches and other techniques that is within their scope of practice.

I acknowledge that the therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder and that nothing said in the course of the session(s) given should be construed as such. I clearly understand that massage therapy is not a substitute for a medical examination, and a referral from your primary care provider may be required prior to services being provided. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment.

I understand that the massage I receive is provided for the basic purpose of therapeutic/relaxation and relief of muscular tension. If I experience any pain or discomfort during the treatment(s) I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort.

Because massage therapy is contraindicated under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I forget to do so.

It is understood that any illicit or sexually suggestive remarks or advances made by me, the client, will result in immediate termination of the session and I will be liable for payment of the scheduled appointment.

Patient/Legal Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Personal Information Consent**

We are committed to protecting the privacy of our client’s personal information and to utilizing all personal information in a responsible and professional manner. This document summarizes some of the personal information that we collect, use, and disclose. In addition to the circumstances described in this form, we also collect, use, and disclose personal information where permitted or required by law.

We collect information from our clients such as names, home addresses, work addresses, personal and work phone numbers, and email addresses. (Collectively referred to as “Contact Information”). Contact information is collected and used for the following purposes:

* To open and update client files.
* To invoice clients for services or collect unpaid accounts.
* To process claims for payment or reimbursement from third-party health benefit providers and insurance companies.
* To send reminders concerning the need for further treatment and/or appointment reminders.
* To send clients informational material about our offices.

Contact information is disclosed to third party health benefit providers and insurance companies where the client has submitted a claim for reimbursement or payment for all or part of the cost of the service or has asked us to submit a claim on the client’s behalf.

We collect information from our clients about their health history and treatments, their family health history, and their physical condition. (Collectively referred to as “Medical Information”). Medical Information is collected and used for the purpose of providing treatment.

Medical Information is disclosed:

* To third party health benefit providers and insurance companies where the client has submitted a claim for reimbursement or payment of all or part of the cost of treatment or has asked us to submit a claim on the client’s behalf.
* To Refresh Wellness Centre practitioners at all locations for client treatment purposes.
* To healthcare professionals such as physicians if the client has been referred by us for treatment.

If we are ever considering selling all or part of our business, qualified potential purchasers may be granted access to client information to verify information important to the potential sale access as part of the due diligence process. If this occurs, we will take steps to ensure that the prospective purchaser safeguards all personal information.

To comply with the Canadian Anti-Spam Legislation in effect as of July 1, 2014, our office would like to have your express consent to continue communicating with you and providing you with important information from us. We are committed to never sending spam emails, and our privacy policy will always protect your electronic information. We do send information and/or communication via email and text for our patients’ convenience. If you decide to opt in and continue receiving emails and texts, you may withdraw your consent at any time.

\_\_\_\_ YES, I give consent to receive communication and appointment confirmations via email and/or text.

\_\_\_\_ No, I do not give consent. I prefer to receive telephone confirmations.

I consent to the collection, use and disclosure of my personal information as outlined above.

Patient/Legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full Name (printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_