PERSONAL INFORMATION

Patients Name: _____
(Print your first and last name)

Address: _____ Apt. # _____

City: _____ Postal Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Date of Birth: Day _____ Month ____ Year ____ Gender: Male _____ Female: ____

Email: _____

Family Physician: _____ Phone: _____

Extended Health Insurance Yes _____ No _____

Insurance Company: _____

Employer: _____

W.S.I.B _____ MVA _____

Claim #: _____ Policy #: _____

Family Physician or Another Physician _____

How did you find about this service? _____

Yellow Pages _____ Road Sign _____ Internet _____ Other _____

Referred by _____

Andrzej Bugiel
Goldsworthy Wellness Centre
168K Lexington Court, Waterloo, ON, N2J 4R9
Phone: 519-886-4814

Goldsworthy
chiropractic & wellness centre

INFORMED CONSENT FOR TREATMENT AND RELEASE

I_____, hereby authorize **Andrzej Bugiel** Registered Physiotherapist and Osteopathic Manual Therapist to exchange, realize and receive my medical records with my attending physician, hospital, insurance company, legal representative, employer, or the Workers Safety Insurance Board (WSIB) and any other Health Care Professionals relevant to my care. I agree to a full assessment and all treatments to be provided by **Andrzej Bugiel** Registered Physiotherapist and Osteopathic Manual Therapist.

I understand that the primary goals of Physiotherapy/Osteopathy treatments are to help reduce my pain and improve my mobility, strength, endurance, function, and quality of life.

I understand that there are possibilities of risks or complications that may result from the Physiotherapy/Osteopathy treatments. I do not expect the Physiotherapist and Osteopathic Manual Therapist to anticipate all the possible risks and complications. Possible risk factors: joint and/or muscle and other soft tissue soreness/pain, discomfort, minor skin irritations such as redness or rash, fatigue, and emotional stress. These effects usually develop within a few hours of a session and typically get better on their own within 1-3 days. In rare cases, serious complication may involve injury, tearing of an artery, stroke, permanent disability, or death. Patient is advised to inform therapist right away of any concerns during a treatment. Patient have right to refuse any part of the treatment now or at any time in the future. The consent may be withdrawn in writing at any time, except for action already taken. During assessment or consecutive treatments, it may be necessary to remove articles of clothing to allow a suitable examination or treatment. You may experience discomfort during or after the examination due to the need to try and reproduce your symptoms. This will then enable the clinician to form a valid clinical impression and treatment plan. Physiotherapy and Osteopathy involves treating the local area of your complaint as well as your body as a whole. During a treatment by the therapist, patient will be touched as it is normal course of therapy. This does not include touching any obvious sexual areas, but common to work on abdomen, back, head, neck, upper and lower extremities, pelvis, sacrum, the inner thighs, buttocks, upper chest, tail bone and pubic bones. Please provide any areas or ways you do not want to be touched:

_____

Yes, I give my consent to treatment: YES / NO

Name: _____

Signature: _____

Date: _____

Andrzej Bugiel
Goldsworthy Wellness Centre
168K Lexington Court, Waterloo ON N2J 4R9
Phone 519-886-4814

Treatment Information and Fee Schedule

I understand that Physiotherapy/Osteopathy treatments may include an individualized exercise prescription and various forms of manual therapy techniques such as mobilization, manipulation, soft tissue release and stretches. Treatments may also include modalities such as heat, ice, therapeutic taping, ultrasound, laser, TENS, interferential current, shock wave and electric muscular stimulation.

I, the patient, understand that I am responsible for the payment of the professional services provided by this clinic. It is my responsibility to pay my bills at the time they are presented to me and submit the receipt to my insurance company for a refund. I understand that any bill not covered by my extended health care plan may be claimed as a tax credit for income tax purpose. I understand that payment for an initial assessment and subsequent treatment are due on the day the service was provided.

Osteopathic treatments subject to HST effective October 12, 2021.

Fee schedule:		Physiotherapy	Osteopathy
Private Initial Assessment:	Adult	$ 85	$85+HST
	Children (0-16 years)	$ 80	$75+HST
	Seniors (65 years +)	$ 80	$75+HST
Private Subsequent Treatments:	Adult	$ 65	$60+HST
	Children (0-16 years)	$ 58	$55+HST
	Seniors (65 years +)	$ 58	$55+HST

Name:

_____

Signature:

_____

Date:

_____

Andrzej Bugiel
Goldsworthy Wellness Centre
168 Lexington Court, Unit K, Waterloo Ontario N2J 4R9
Phone: 519-886-4814

Goldsworthy
chiropractic & wellness centre

MEDICAL HISTORY FORM

PATIENT NAME: _____ DATE OF BIRTH: _____

MEDICAL HISTORY **Please check off all the following conditions you presently have or have had.**
(Not sure, check off NS)

	No	Yes	NS		No	Yes	NS		No	Yes	NS
Cold extremities				Sinus Trouble				Artificial Joints/Hips/Knees etc.			
Stomach/Intestinal Problems				Frequent Cough				Diabetes or Hypoglycemia			
Thyroid Disease				Lung Disease				Arthritis/Rheumatism			
High Blood Pressure/Hypertension				Liver Disease				Epilepsy or Seizures			
Low Blood Pressure				Weakness in Arms/Legs				Psychiatric Care			
Heart Disease				Osteoporosis				Nervous Disorders			
Artificial Heart Valve				Dislocations				AIDS (HIV positive)			
Heart Pacemaker				Yellow Jaundice				Skin Diseases			
Heart Surgery				Headaches				Circulation problems			
Chest Pain				Low back pain				Cancer			
Shortness of Breath				Pain in jaw joints				Chemotherapy/Radiation			
Stroke				Head/Neck injuries				X-Rays			
Fainting or Dizziness				Bulging disc/fusion				Numbness			
Cardiac Arrest/Heart Attack				Hearing Problems				Constipation			
Swelling of Feet/Ankles/Hands				Allergies				Depression			
Kidney Trouble				Asthma							
Recent Fractures, date:				If yes, have you received treatment?							

Is there anything we have not mentioned that you think we should know regarding your medical history?

_____

_____

_____

_____

_____

_____

_____

Are you pregnant? Yes □ No □

Follow-up information to above questions:

_____

_____

_____

_____

Patient Signature: Date:

Andrzej Bugiel
Goldsworthy Wellness Centre
168K Lexington Court Waterloo, Ontario N2J 4R9
Telephone: 519-886-4814

MISSED APPOINTMENT AND LATE CANCELLATION FEE POLICY

We're glad you have chosen us to provide you with your health care. Your practitioner books your appointments to keep you in top shape. When you miss or cancel your appointment you affect your health and those of clients that could have used that time.

Our Centre requires 48 business hours' advanced notice in the event you need to reschedule or cancel an appointment. Appointments on Monday must be cancelled before the scheduled appointment time on the previous Thursday.

Full treatment price will be charged for appointments missed, cancelled, or rescheduled with less than 48 hours' notice.

Please be aware that in some cases repeat missed appointments can lead to termination of services. None of these fees are insurance reimbursable.

I _____, have read the above information that explains the missed appointment, late cancellation, and rescheduling fee policy. I understand that at least 48 business hours' notice is required to avoid these charges.

Signature: _____ Date: _____

Andrzej Bugiel
Goldsworthy Wellness Centre
168K Lexington Court, Waterloo, ON N2J 4R9
Phone: 519-886-4814

PATIENT PRIVACY CONSENT FORM

Privacy of your personal information is an important part of our office providing you with quality chiropractic care. We understand the importance of protecting your personal information. We are committed to collecting, using, and disclosing your personal information responsibly. We also try to be as open and transparent as possible about the way we handle your personal information. It is important to us to provide this service to our patients.

In this office, Dr. Jeff Goldsworthy acts as the Privacy Information Officer.

All staff members who encounter your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are all trained in the appropriate uses and protection of your information.

In this consent form, we have outlined what our office is doing to ensure that:

*only necessary information is collected about you
*we only share your information with your consent
*storage, retention and destruction of your personal information complies with existing legislation and privacy protocols
*our privacy protocols comply with legislation, standards of our regulatory bodies and the law

Do not hesitate to discuss our policies with Dr. Jeff or any member of our staff. Please be assured that every staff member in our office is committed to ensuring that you receive the best quality Health Care.

HOW OUR OFFICE COLLECTS, USES AND DISCLOSES PATIENT'S PERSONAL INFORMATION

Our office understands the importance of protecting your personal information. To help you understand how we are doing that, we have outlined below how our office is disclosing your information.

This office will collect, use, and disclose information about you for the following purposes:
*to deliver safe and efficient patient care
*to identify and to ensure continuous high quality service
*to assess your health needs
*to provide health care
*to advise you of treatment options
*to enable us to contact you
*to establish and maintain communication with you
*to offer and provide treatment, care and services
*to communicate with other treating health care providers, including but not limited to specialists, referring doctors, family doctors, massage therapists, naturopaths
*to allow us to maintain communication and contact with you to distribute health care information and to book and confirm appointments
*to allow us to efficiently follow-up for treatment, care and billing
*for teaching and demonstrating purposes on an anonymous basis
*to complete and submit claims for third party adjudication and payment
*to comply with legal and regulatory requirements, including the delivery of patient's charts and records to governing bodies in a timely fashion, when required, according to the provisions of the Regulated Health Professions Act
*to comply with agreements/undertakings entered into voluntarily by the member with governing bodies, including the delivery and/or review of patient's charts and records in a timely fashion for regulatory and monitoring purposes
*to permit potential purchasers, practice brokers or advisors to evaluate the practice
*to allow potential purchasers, practice brokers or advisors to conduct an audit in preparation for a practice sale
*to deliver your charts and records to the office's insurance carrier to enable the insurance company to assess liability and quantify damage, if any
*to prepare materials for the Health Professions Appeal and Review Board (HPARB)
*to invoice for goods and services
*to process credit card payments

*to collect unpaid accounts
*to assist this office to comply with all regulatory requirements
*to comply generally with the law

By signing the consent section of this Patient Consent Form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information for the purposes that are listed. If a new purpose arises for the use and/or disclosure of your personal information, we will seek your approval in advance.

Your information may be accessed by regulatory authorities under the terms of the Regulated Health Professions Act (RHPA) and for the defense of a legal issue.

Our office will not under any condition supply your insurer with your confidential medical history. In the event this kind of request is made, we will forward the information directly to you for review, and for your specific consent. When unusual requests are received, we will contact you for permission to release such information. We may also advise you if such a release is inappropriate.

You may withdraw your consent for use or disclosure of your personal information, and we will explain the ramifications of that decision and the process.

Patient Consent

I have reviewed the above information that explains how your office will use my personal information and the steps your office is taking to protect my information.

I know that your office has a Privacy Code, and I can ask to see the Code at any time.

I agree that Goldsworthy Chiropractic and Wellness Centre can collect, use, and disclose personal information about: (Patient's name) _____
As set out above in the information about the office's privacy policies.

Signature _____

Print Name _____
(Print name and relationship to patient if signing for a child under 16)

Date _____ Signature of Witness _____

Andrzej Bugiel
Goldsworthy Wellness Centre
168K Lexington Court, Waterloo ON N2L 4R9
Tel: 519-886-4814