Dynamic Physiotherapy & Wellness Centre

WCB Intake Form

First Name: _____ Last Name: _____

Alberta Health # _____ WCB Claim #: _____

Address: _____ City: _____

Postal Code: _____ Email: _____

Do you consent to Dynamic Wellness sending newsletters, updates and reminders to your email? Yes/no

Home Phone: _____ Work Phone: _____ DOB: _____

Occupation: _____ Employer: _____

Employer Address: _____ City: _____ Postal Code: _____

Supervisor (person who would coordinate return to work) _____ Phone: _____

Date of Injury: _____

First Medical Professional seen following injury: _____ Date: _____

Are you currently working? yes/no (if yes: pre-accident duties/modified duties)

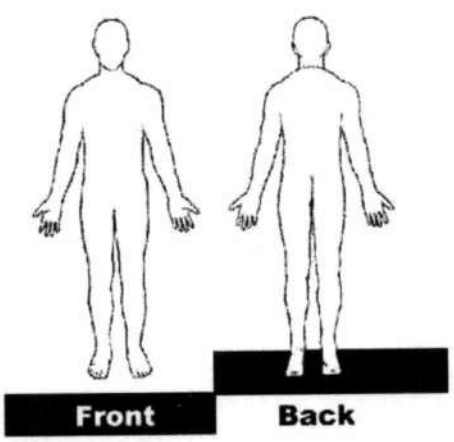
Name of your family doctor: _____

Do you have any allergies? yes/no (if yes, please list): _____

Do you have any of the following medical conditions (please circle those that apply)

Heart Disease **High Blood Pressure** **Diabetes** **Arthritis** **Cancer**

Please circle the areas where you are experiencing pain or discomfort



Dynamic Physiotherapy
& Wellness Centre

Describe in your own words your present symptoms: _____

_____

Describe how the injury occurred: _____

_____

List any other medical conditions you have: _____

List any medications you are presently taking: _____

Is there a possibility you may be pregnant? Y N Are you nursing? Y N

Following your initial visit, your therapist will send a report to the WCB. The WCB will resond back authorizing treatment. You may choose to be treated while awaiting approval from WCB.

In the event your claim is denied by WCB for any reason whatsoever, you agree to accept full responsibility for any and all treatments provided by Dynamic Physiotherapy & Wellness Centre and will provide full payment to Dynamic Physiotherapy & Wellness Centre for all services provided immediately upon receiving notification that your WCB claim has been denied.

Patient Signature: _____

Date: _____

Dynamic Physiotherapy & Wellness Centre

Consent to Assess and Treat

I understand that in order to determine appropriate treatment for the condition for which I have that I will have to undergo a physical examination which may involve questioning, observing, hands-on assessment of areas of the body, and disrobing to some degree as deemed appropriate at the time of examination. I also understand that consent to be assessed may be withdrawn at any time.

Physical Therapy and/or Acupuncture

I recognize and approve that I will be receiving treatment which may involve the use of electro physical agents (including ESWT), thermal or mechanical modalities, hands-on muscular or joint therapy, as well as instruction in various exercises. In the event that acupuncture is desired, I understand and accept that needles will be placed directly into structures beneath the skin, and that all treatments may require that I disrobe to some degree. Furthermore, consent to be treated may be withdrawn at any time.

I have read and I understand and accept the above statements.

NAME: _____(Print)

_____(Signature)

Date: _____, 201___.

DISCLAIMER: In the event your WCB claim is denied we will need to bill you or your extended health care coverage.

Electronic Transmission Authorization and Consent Form

Instructions: This form must be filled out when claims are submitted electronically by the provider on the patient's behalf. Please retain this form in the patient's file for verification purposes for two years following closure of the patient file.

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 service provider(s) for the purposes 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 reinsurers, and administrators of government benefits or other benefits 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 the plan member.
- exchange personal information for the above purposes electronically or in any other manner.

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.

Additional Consent Applicable to Plan Members Only

I confirm that I am authorized by my spouse and/or dependents, if any, to disclose personal information about them to the insurer and/or plan administrator and their service provider(s) for the purposes described above and I confirm that my spouse and/or dependents also authorize the insurer and/or plan administrator and their service provider(s) to disclose information about their claims to me, for the purposes of assessing and paying a benefit, if any, and managing the group benefits plan. I also authorize my spouse and/or dependents to assign benefit payments under the plan to the healthcare provider.

In the event there is suspicion and/or evidence of fraud and/or plan abuse concerning claims submitted, I acknowledge and agree that the insurer and/or plan administrator and their service provider(s) may use and disclose relevant personal information to any relevant organization including law enforcement bodies, regulatory bodies, government organizations, medical suppliers and other insurers, and where applicable my Plan Sponsor, for the purposes of investigation and prevention of fraud and/or plan abuse.

If there is an overpayment, I authorize the recovery of the full amount of the overpayment from any amount payable under the group benefits plan, and the exchange of personal information with other persons or organizations, including credit agencies and, where applicable, my Plan Sponsor, for that purpose.

Company:_____ **Plan Number:**_____ **Certificate Number:** _____

Date:_____ **Signature:**_____