

New Patient Form

Welcome, and thank you for choosing Thornhill Rehabilitation and Chiropractic Centre. We offer quality professional, affordable health care. Direct and open communication between you and the therapist is vital for proper care. We ask that you fill out the following forms to insure that you receive the appropriate care that you require. Please note all information is confidential.

Please tell us about yourself:

Name: Mr. Mrs. Miss Ms Dr.
 Last Name: _____
 First Name: _____
 Date of Birth: Day _____ Month _____ Year _____
 Address: _____
 City: _____ Province: _____ Postal Code: _____
 Phone: Home (____) _____ Work (____) _____
 Cell: (____) _____ Email: _____
 Occupation: _____
 Emergency Contact: _____ Phone:(____) _____

Previous Therapy:

Physiotherapy Chiropractic Massage Therapy Acupuncture Other

Clinic Name: _____

Therapist Name: _____

Family Doctor: _____ **Phone:** _____

Address: _____

How did you hear about us?

Google Website Link: _____ White Pages Yellow Pages
 Doctor Referral: _____ Referral (By Whom) _____
 Walk In Newspaper Ad/Brochure (Location) _____ Other: _____

Would you like to be added to our quarterly email newsletter filled with health information and exercise tips? Yes No

Please see reverse...



Consent Waiver

NOTE TO CLIENT

We want your informed consent. This means that we want you to understand the services we hope to provide to you, the cost involved, and what we do with personal information we obtain about you. If you have any questions, please ask.

CONSENT TO HISTORY AND PHYSICAL EXAM

I am aware that the doctor or therapist will perform a comprehensive patient history and physical exam related to my complaint. I understand that I am allowed to ask questions at any time about the process and may ask to stop the exam if deemed necessary. I will allow the doctor or therapist to use his or her clinical judgment in deciding which tests are most appropriate for my complaint.

CONSENT FOR THE COST OF OUR SERVICES

Please review the attached "Fee Schedule" and Cancellation Policy.

I, _____ hereby agree that I fully understand the fees for service and that I am responsible to make payments for any services provided.

CONSENT FOR PERSONAL INFORMATION

I understand that to provide me with Health Professional Services, Thornhill Rehabilitation and Chiropractic Centre (TRCC) will collect some personal information about me (e.g., telephone number, address, gender, health history).

I am aware that TRCC has a Privacy Policy about the collection, use and disclosure of personal information, steps taken to protect the information and my right to review my personal information. I understand how the Privacy Policy applies to me. I have been given a chance to ask any questions I have about the Privacy Policies and they have been answered to my satisfaction.

I understand and give my consent

If necessary I authorize and direct TRCC to release to my: Physician, Insurance Company, Case Worker, WSIB, or other Health Care Providers, medical reports, x-rays and any other information as requested.

I understand that, as explained in the Policies and Procedures for Personal Information, there are some rare exceptions to these commitments.

I agree to TRCC collecting, using and disclosing personal information about me as set out above and in the TRCC's Privacy Policy.

SIGNATURE: _____ PRINTED NAME: _____

DATE: _____ WITNESS SIGNATURE _____

NOTES by TRCC: _____