Balance Point Health Centre Inc.
465 Morden Rd., Suite 110
Oakville, Ont. L6K 3W6
(289) 291-0254

Patient Intake Form

Patient Name_____ Birthday (mm/dd/yyyy)_____

Address_____ City _____

Postal Code_____ Phone Number Home ( )_____

Phone Number Work ( )_____ Email _____

Physician_____ Phone Number_____

Emergency Contact _____ Relationship_____

Phone Number ( )_____

How did you hear about our clinic? Friend or Family _____Other_____

Would you like to receive our newsletter? Yes/No _____

Have you had or do you have any of the following?

Arthritis or Rheumatism _____
Asthma _____ Medications_____
Allergies _____
Diabetes _____Medications_____
Increased or Decreased Skin Sensations_____
Epilepsy _____Date Diagnosed_____Medications_____
Fainting/ Dizziness_____
Headaches_____
Heart Condition_____Medications_____
Painful Joints_____
Skin Problems_____
Swollen Joints_____
Blood Pressure Conditions_____Medications_____
Metal Implants_____
Pace Maker_____Surgery Date_____
Circulation Problems_____
Dislocating Joints_____
Cancer _____Treatment/ Date_____
Bowel/ Bladder Problems_____
Menstrual Problems_____
Sexual Dysfunction_____

Balance Point Health Centre Inc.

Previous Injuries/ Falls, If so please elaborate;

_____
_____
_____
_____
_____
_____
_____
_____

Main Complaint For Appointment _____

When Did Injury Occur? _____

Have you seen your Doctor_____ When _____

Advice/Investigations_____

_____

Treatment for injury to date (what types/ length of treatment? Outcome)

_____

_____

Surgeries_____

_____

Child Birth: Number of pregnancies_____ Number of Births_____

Episiotomy_____ Degree_____ Tearing_____

Degree of Tearing_____ Epidural_____

Any lasting effects/ problems of Epidural_____

Car Accidents:

_____

_____

465 Morden Road, Suite 110, Oakville, ON L6K 3W6 • Phone: 289-291-0254
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STATEMENT OF ACKNOWLEDGEMENT AND CONSENT TO TREATMENT

THIS FORM MUST BE SIGNED BEFORE ANY TREATMENT WILL BE RENDERED

Osteopathic medicine believes that a patient's history of illnesses and physical traumas are written into the body's structure. It is the Osteopath's job to "set" the body up to heal itself. To restore normal function, the Osteopath gently applies a precise amount of force to promote movement of the body fluids, eliminate dysfunction in the motion of the tissues, and release compressed bones and joints. In addition, the areas being treated require proper positioning to assist the body's ability to regain normal tissue function.
In order to clarify my position as your health care practitioner, I ask for your cooperation in signing this statement of acknowledgement, in so doing:

That you understand that (please check ✓) one of the following therapists you will be seeing today:

☐Dave Ellis, C.A.T.(C), DO(MP), Certified Athletic Therapist, Diploma in Osteopathic Manual Practice

☐Michael, Misa, Todosijevic, B.Sc., D.O.M.P., Diploma in Osteopathic Manual Practice

Osteopathic Manual Practitioners are not doctors; we use non-invasive manual methods of assessment and treatment of body dysfunctions. That any treatment you receive is not mutually exclusive from any treatment or advice you may now be receiving or may receive in the future from another licensed health care provider.

That you understand that methods I may use have a proven clinical foundation, yet may not be accepted by standard (allopathic) medicine.

That you understand that I am required by my licensing board to perform a physical examination on each new patient.

That you understand any treatment and/or referral to other health practitioners is based on the assessment of your health, revealed through your personal history and physical examination, including palpation and treatment. You are at liberty to seek or continue medical care from a physician or surgeon or other health care provider qualified to practice in Ontario.

That you understand I reserve the right to determine which cases fall outside my scope of practice, in which event the appropriate referral will be recommended.

That while changes in lifestyle habits are not an absolute prerequisite for treatment, that you understand failure to follow sound nutritional, exercise, and lifestyle programs could undermine expected results.

That you are accepting or rejecting this care of your own free will.

That you understand that the ultimate responsibility for your health care is your own, and that I am here to support you in this. I reserve the right to discontinue my services where it is apparent that your expectations and what I can provide are not in agreement.

That you understand all fees for services are payable at the time of the appointment by the patient or guardian.

That there is a fee for completing insurance forms and letter writing. Notice of 24 hours is required for appointment cancellation, otherwise you will be charged an administration fee of $55.00.

I, _____ have read and understood and acknowledge the above statements.

SIGNATURE OF PATIENT OR GUARDIAN_____

DATE_____

PRIVACY INFORMATION CONSENT FORM

FOR COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

Privacy of your personal information is an essential part of our office providing you with quality 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.
All staff members who come in contact with 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;

Please be assured that every staff person in our office is committed to ensuring that you receive the best quality care.

HOW OUR OFFICE COLLECTS, USES AND DISCLOSES PATIENTS' 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 using and 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 specialists and referring doctors WITH YOUR CONSENT
- To allow us to maintain communication and contact with you to distribute healthcare information and to book and confirm appointments
- To allow us to efficiently follow-up treatment, care and billing
- To invoice for goods and services
- To collect unpaid accounts
- To assist this office to comply with all regulatory requirements
- To comply with the general 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 listed. If a new purpose arises for the use and/or disclosure of your personal information, we will seek your approval in advance.

Our office will not, under any conditions, 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 appropriate.

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 agree that Balance Point Health Care Inc. can collect, use and disclose personal information about

_____ as set out above in the information.
(Patient's Name)

Print Name: _____ Signature: _____

Date: _____