



Balance Point Health Centre Inc.

465 Morden Rd., Suite 110
Oakville, ON L6K 3W6
Phone: (289) 291-0254 Fax: (289) 291-0255

Osteopathic Patient Intake Form

Patient Name: _____ Birthdate (mm/dd/yyyy): _____

Address: _____ City: _____

Postal Code: _____ Email: _____

Phone Number Home: _____ Phone Number Cell/Work: _____

Family Physician: _____ Phone Number: _____

Emergency Contact Name: _____ Relationship: _____

Phone Number: _____

How did you hear about our clinic? Friend / Family: _____ Other: _____

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: _____ Frequency: _____

Heart Condition: _____ Medications: _____

Pace Maker: _____ Surgery Date: _____

Circulation Problems: _____

Blood Pressure Conditions: _____ Medications: _____

Painful Joints: _____

Skin Problems: _____

Swollen Joints: _____

Metal Implants: _____

Dislocating Joints: _____

Cancer: _____ Treatment/ Date: _____

Bowel/ Bladder Problems: _____

Menstrual Problems: _____

Sexual Dysfunction: _____

Previous Injuries/ Falls: If so, please elaborate:

Main complaint for appointment: _____

When did the injury occur? _____

Have you seen your Doctor: **YES NO** If Yes, 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/Spinal: _____ Any lasting effects/problems of Epidural: _____

Car Accidents: _____

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 our position as your health care practitioner, we ask for your cooperation in signing this statement of acknowledgement. In so doing:

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

- Dave Ellis**, DO(MP), Diploma in Osteopathic Manual Practice

- Michael (Misa) Todosijevic**, B.Sc., DO(MP), Diploma in Osteopathic Manual Practice

Manual Practice Osteopath is not a doctor; that 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 we may use have a proven clinical foundation yet may not be accepted by standard (allopathic) medicine.

That you understand that we are required by our 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 we 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 we are here to support you in this. We reserve the right to discontinue my services where it is apparent that your expectations and what we 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 the total fee of the appointment time booked.

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
- 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. 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 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 of Patient or Guardian

Date