Kinetic Performance Center

408-1011 Glenmore Trail SW
Calgary, Alberta T2V 4R6

Phone: (587)955-9910
Fax: (587)955-9911

Patient Information

Date: _____
Last name: _____
First Name: _____ Middle Initial: _____
Date of Birth (M/D/Y) _____ Age: _____ Sex: M F

Address: _____
City: _____ Province: _____ Postal Code: _____

***Alberta Health Care Number: _____**

Phone Numbers:	Area Code	Number	Extension
Home	_____	_____	_____
Phone (bus):	_____	_____	_____
Phone (cell):	_____	_____	

Email Address: _____

Automated Email Reminders: o 1 day before o 2 days before o No reminder

Referral:

□ Personal Referral _____ □ Internet
□ Doctor Referral _____ □ Phone Book
□ Physiotherapist _____ □ Walk-In
□ Massage Therapist _____
□ Other: (please specify) _____

Family Doctor (Required): _____
Business Employer: _____Type of Work: _____
Emergency Contact Name : _____Phone Number: _____

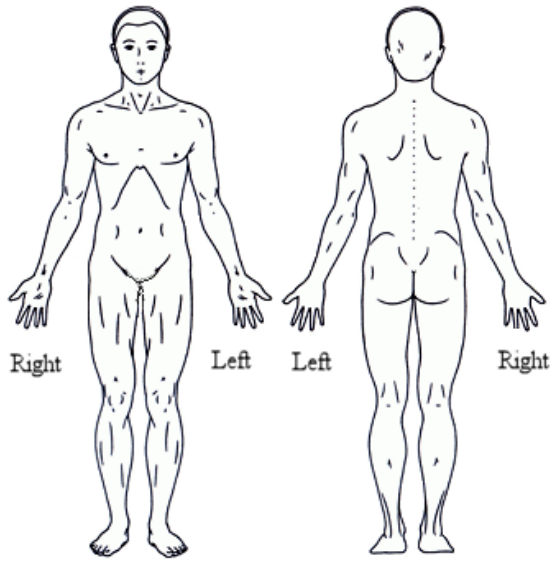
Do you have Extended Health Coverage? □ Yes □ No
If yes, please see Direct Billing Authorization and Benefit Assignment forms

Are you a being treated and covered by an insurance company for a motor vehicle accident
□ Yes □ No

Current Health Condition

Purpose of this Appointment: _____
Major Complaint: _____
Explain How Complaint Occurred: _____
When Did This Condition Begin: _____
Condition Has Persisted For: □ Days □ Weeks □ Months □ Years
Condition Developed From: □ Auto Accident □ Work Injury □ Other Injury _____
Symptoms: □ Came on Suddenly □ Come & Go
What Activities Make Condition Better? _____
What Activities Make Condition Worse? _____
Symptoms are BETTER in: □ AM □ Midday □ PM
Symptoms are WORSE in: □ AM □ Midday □ PM □ Do not change with time of day
Have you ever had this condition before? □ No □ Yes, when _____
Other doctors seen for this condition: _____
Describe Other Complaints Involving: Neck/Head: _____
Mid-Back/Shoulders/Arms: _____
Low-Back/Hips/Legs: _____
Medications you are presently taking: _____
For what conditions: _____
Previous Chiropractic Care: _____
All Accidents or Falls: _____
Surgeries and Operations: _____
Hospitalizations: _____
Date of Last Spinal X-Rays: _____ Where? _____
Women: Are You Pregnant? □ Yes □ No Date Onset Last Cycle: _____

Use the following symbols to mark where the pain is:



Please circle degree of pain, 0 none, 10 severe pain.
0 1 2 3 4 5 6 7 8 9 10
Using the symbols below, mark on the pictures where you feel pain.

Numbness	= = =
Dull Ache	****
Burning	XXX
Sharp/Stabbing	/ / /
Pins, Needles	+ + +
Stiff and Tight	~~~~

Past Health History

CHECK ANY DISEASES YOU HAVE HAD:

□ Rheumatic Fever
□ Diabetes
□ Heart Disease
□ A.I.D.S.
□ Measles
□ Small Pox
□ Cancer
□ Arthritis
□ Pneumonia
□ Mumps
□ Chicken Pox
□ Influenza

CHECK ANY OF THE FOLLOWING CONDITIONS YOU HAVE HAD:

MUSCULO-SKELETAL
□ Low Back Pain
□ Pain between Shoulders
□ Neck Pain
□ Arm Pain
□ Joint Pain/Stiffness
□ Walking Problems
□ Difficult Chewing/Clicking Jaw
□ General Stiffness

CARDIO-VASCULAR
□ Blood Pressure Problems
□ Heart Problems
□ Lung Problems/Congestion
□ Stroke
□ Chest Pains

MALE/FEMALE
□ Menstrual Irregularity
□ Menstrual Cramping
□ Vaginal Pain/Infections
□ Breast Pain/Lumps
□ Prostrate/Sexual Dysfunction

NERVOUS SYSTEM
□ Nervous
□ Numbness
□ Dizziness
□ Forgetfulness
□ Confusion/Depression
□ Fainting
□ Convulsions
□ Cold/Tingling Extremities
□ Stress

DIGESTIVE TRACT
□ Nausea
□ Heartburn
□ Gas/Bloating after Meals
□ Constipation
□ Diarrhea
□ Bowel Infections
□ Weight Trouble

EYE/EAR/NOSE/THROAT
□ Vision Problems
□ Sore Throat
□ Stuffed Nose and Sinuses
□ Hearing Difficulty
□ Ear Aches

GENERAL
□ Fatigue
□ Allergies
□ Loss of Sleep
□ Headaches
□ Fever

GENITO-URINARY
□ Bladder Trouble
□ Painful Urination
□ Excessive Urination

EXERCISE (check one)
□ none o moderate o daily
What? _____
_____
_____

FAMILY HISTORY (For example, Cancer/Diabetes/ Heart Problems/Back or Neck Problems)

Father: _____
Mother: _____
Siblings: _____

HABITS

□ Smoking: pks/day: _____
□ Drinking: alcohol/wk: _____
□Coffee: cups/day: _____

I confirm that the information I have provided in regards to my current condition and past health history are true to the best of my knowledge.

Signature: _____ **Date:** _____

Direct Billing Authorization Form

*Kinetic Performance Center (KPC) is able to provide direct billing for some services provided depending on the client's insurance provider.
*Every insurance contract is different and we have no way of knowing the limits for each individual policy.
*It remains each client's responsibility to provide payment in full for services provided at this clinic regardless of insurance coverage.
***Please be advised there is a <u>one-time $25.00 fee</u> to register for Direct Billing with Kinetic Performance Center**

We offer direct billing for patients who have benefits via the following:

- Great West Life
- SunLife
- Manulife
- Standard Life
- Desjardins
- GreenShield
- Alberta Blue Cross

<u>Direct Billing Terms</u>:

- The primary insurance account holder must be present to complete the required billing forms.
- A credit card number and signature must be kept on file in order to initiate direct billing.
- The credit card will be billed for any service amounts not covered by the insurance provider as well as any missed appointments. Please refer to the 'Explanation of Fees' form for missed appointment policy.
- Account and billing summaries will be provided at patient request within 2 business days of any request.
- We will attempt to notify clients of any difficulties encountered with submitting billing to insurance providers (i.e. incomplete information, partial coverage, co-payment required). If we are unable to contact the client to resolve outstanding billing issues then the credit card provided will be charged for any outstanding amounts. It remains each client's responsibility to provide payment in full for services provided at this clinic regardless of insurance coverage.

☐ I have read the above terms and give Kinetic Performance Center permission to direct bill my insurance provider following a one-time $25 fee.

☐ I will pay the full cost at the time of service and submit to my insurance company myself.

Benefit Assignment Form

[Please complete if you agreed to the previous page]

Provider: _____
Plan (Policy) Number: _____
Plan Member (ID) Number: _____

Plan Holder Name (If different than Patient):_____
Plan Holder DOB (If different than Patient): _____

I hereby assign benefits payable for the eligible claims to the Provider responsible for submitting my claims electronically to the group benefits plan and I authorize the insurer/plan administrator to issue payment directly to the Provider. In the event my claim(s) are declined by the insurer/plan administrator, I understand that I remain responsible for payment to the Provider for any services rendered and/or supplies provided.

I acknowledge and agree that the insurer/plan administrator is under no obligation to accept this Assignment, that any benefit payment made in accordance with this Assignment will discharge the insurer/plan administrator of its obligations with respect to that benefit payment, and that in the event payment is made to me, the insurer/plan administrator will also be discharged of its obligation with respect to that benefit payment.

I understand that this Assignment will apply to all eligible claims submitted electronically by the Provider and that I may revoke it at any time by providing written notice to the insurer/plan administrator.

If I am a spouse or dependent, I confirm that I am authorized by the plan member to execute an assignment of benefit payments to the Provider.

_____ _____
Signature Date

_____
Name (Please Print)

Kinetic Performance Center Fee Schedule

Services	Consists Of	Cost of Treatment
Chiropractic Initial Assessment with Treatment *New Chiropractic Patients	• Discussion of health issues and injuries • Case history review and exam findings • Discussion of physical examination findings and treatment options • Initial treatment	$130.00
Chiropractic Reassessment with Treatment * Chiropractic patients that have not been in the clinic for 1 year or more	• Discussion of health issues and injuries • Case history review and exam findings • Discussion of physical examination findings and treatment options • Treatment	$110.00
Active Release Techniques, Graston and Adjustments	• Please ask for more information about these therapies	$68.00
Kinesiotaping	• Please ask for more information about these therapies	$5.00
Shockwave Therapy	• Please ask for more information about these therapies	$103.00
Physiotherapy Initial Assessment with Treatment *New Physiotherapy Patients / patients that have not been in the clinic for 6 months or more / new injury or different body part being treated	• Discussion of health issues and injuries • Case history review and exam findings • Discussion of physical examination findings and treatment options • Initial treatment	$130.00
Physiotherapy Treatment Sessions	• Supervised exercises and rehabilitation programs • Therapy procedures • Intramuscular Stimulation (IMS)	$100.00
Massage Therapy	• Acupressure, Thai Massage, Sports Massage, Deep Tissue, Relaxation, Reflexology, Orthopedic Massage, Prenatal Massage	30 min = $70.00 45 min = $80.00 60 min = $95.00 90 min = $125.00 *Plus GST
Direct Billing Fee	• A one-time fee for the clinic to direct bill insurance providers	$25.00

****Prices effective as of February 1, 2018****

Special senior and full time student rates available. ID may be required.

Payments

Forms of Payment:
Patients are responsible for full payment at the time services are rendered. We accept Interac, Visa, MasterCard, personal cheque and cash. Any credit arrangements must be authorized in advance by the practitioner. For Motor Vehicle Accident injuries, please inquire regarding fees and policies.

Missed/Cancellation Appointment Policy:
Our office requires 24 hours' notice for cancellation of appointment. Appointments missed or cancelled without sufficient notice will be charged half the cost of the treatment.

Credit Card Authorization

I _____ authorize Kinetic Performance Center to bill the credit card below for any services provided by Kinetic Performance Center which are not paid for personally, covered by my insurance provider, as well as any missed appointments. I have read, understood and agreed to the fees and payment obligations as listed above. I intend this authorization to cover all charges incurred at Kinetic Performance Center. I understand that this authorization may be revoked at any time by providing written notice to Kinetic Performance Center.

Card Type: ____Visa ____ MasterCard

Card #:_____
Expiry date: _____

Authorized Signature: _____

PROTECTING YOUR PERSONAL HEALTH INFORMATION

under the Alberta Health Information Act

WHAT IS THE HEALTH INFORMATION ACT?

The Alberta Health Information Act or HIA is a provincial law that aims to balance your right to have your health information protected with the need of health professionals to use your information to provide you with proper care and treatment.

WHAT IS HEALTH INFORMATION?

Health information is information about you that is related to your health or health care. It may include:

- your name;
- address;
- date of birth;
- health history;
- provincial health card number;
- other information about tests, procedures and care you received

Kinetic Performance Center (KPC) collects health information directly from you or the person acting on your behalf. Sometimes, KPC asks other health professionals or health care organizations involved in your health care for your health information to help its practitioners provide you care. KPC may collect health information from other sources, if KPC has your permission to do so, or if the law allows KPC to do so even without your permission. Health Information may be collected and stored in different ways, including electronic files, on paper charts, and images like x-rays. KPC collects health information as needed to treat you and assist with your health care.

WHO CAN SEE OR USE YOUR HEALTH INFORMATION?

• individuals involved in your care and treatment, including students, on a need to know basis
• individuals who need the information to get payment for your health care
• anyone who can legally act on your behalf
• specified organizations who have a legal right to see the information in certain situations

HOW DOES HIA PROTECT YOUR HEALTH INFORMATION?

KPC has policies and practices to protect your health information. KPC will:

• properly collect, use, share, keep and destroy your health information following the rules in HIA
• have a Privacy Officer who can answer your questions about our handling of your health information
• has policies to protect the privacy and security of your health information on paper, in electronic form, or unrecorded
• has a complaints policy for you to use if you believe that we are not following the rules in HIA
• properly respond if the privacy of your health information has been breached. This may include telling you or the Privacy Officer.

WHAT ARE YOUR RIGHTS UNDER HIA?

• to ask for copies of your health information (fees may apply)
• to ask for changes to your health information if the facts were not recorded correctly
• to ask that some or all of your health information not be collected by, used by, or shared with specific people or organizations involved in your care
• to ask for a review by the Privacy Review Officer responsible for HIA if you do not think the result of your complaint, access request, or correction request properly followed the rules in *HIA*.

WHO DO I CONTACT FOR MORE INFORMATION?

This is a summary of your rights and our responsibilities under HIA. There are specific exceptions to these rights and responsibilities.

If you need more information, please ask our HIA Privacy Officer:

Darren Yick
DrYick@KineticPerformanceCenter.ca
(587) 955-9910

Patient Consent

By signing the consent section of this Patient Consent From, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your health information.

I have reviewed the above information that explains how your office will use my health information, and the steps your office is taking to protect my information. I know that your office has a Privacy Policy, and I can ask to see the Policy at any time.

I agree that Kinetic Performance Center can collect, use, and disclose health information about _____ as set out above in the information about the office's privacy policies.

Print Name _____ Patient Signature _____

Date _____ Witness _____

For general information on HIA, visit the Office of the Information and Privacy Commissioner of Alberta (OIPC) website: www.oipc.ab.ca/pages/HIA/AboutAct.aspx
or reach OIPC contact at 1-780-422-6860, toll-free at 1-888-878-4044 or by email at generalinfo@oipc.ab.ca

CONSENT FORM – DRY NEEDLING

Intramuscular Manual Therapy IMT / Functional Dry Needling (FDN) / Acupuncture

Dry needling is the use of solid filiform needles for therapy of muscle pain, also known as intramuscular stimulation (IMS) which is similar to acupuncture techniques. Such use of a solid needle has been found to be as effective as substance injections in relief of pain in muscles and connective tissue.

Dry needling for the treatment of myofascial (muscular) trigger points is based on some similar theories to traditional acupuncture; however, dry needling targets the trigger points versus the traditional 'meridians' accessed via acupuncture. By needling the direct source of patient pain with the intent of causing the muscle to contract and then release, flexibility of the muscle improves and therefore decreases symptoms.
IMT/FDN and Acupuncture are valuable treatments for musculoskeletal-related pain such as soft tissues, joint pain, and to increase muscle performance. Like any treatment, there are possible complications that are rare but should be read prior to giving consent to treatment.

RISKS OF THE PROCEDURE: Though unlikely, there are risks associated with this treatment. The most serious risk with Dry Needling is accidental puncture of a lung (pneumothorax) when performing around the chest wall and thoracic spine. If this were to occur, it may likely only require a chest x-ray without further treatment as this injury can repair itself; the symptoms of pain and shortness of breath may last several days to weeks. A more severe lung puncture can require hospitalization and lung re-inflation, which is very rare and should not be of concern. If you feel any related symptoms, immediately contact your provider. If you suspect pneumothorax, seek medical attention from your physician or emergency room if necessary.

Other risks may include bruising and infection. Bruising is a common occurrence and should not be of concern unless taking blood thinners. As the needles are very small and without a cutting edge, the likelihood of significant tissue trauma from IMT/FDN and Acupuncture is unlikely. Please inform your provider if you have any conditions that can be transferred by blood, require blood anticoagulants, or any other conditions that may have adverse effect to needle punctures.

Please consult with your practitioner if you have any questions regarding the treatment above.

YES NO Do you have any known disease or infection that is transmitted through bodily fluids?

YES NO Are you immune compromised?

YES NO Are you taking blood thinners?

YES NO Are you pregnant?

IF YOU CIRCLE 'YES' TO ANY OF THESE QUESTIONS, PLEASE DISCUSS WITH YOUR PRACTITIONER.

Our clinic requires 24 hours notice for cancellation of physiotherapy appointments. Appointments missed or cancelled without sufficient notice will be charge half the cost of treatment.
If the patient has a new injury or it has been more than 6 months between appointments for the same injury, the physiotherapists reserve the right to charge an initial assessment fee of $125.
I understand that the practitioner applying Dry Needling techniques has completed the training required and is certified. I understand that this consent is recommended by the agencies that trained the provider to assure safe practice of Dry Needling and the practitioner is part of the Dry Needling roster of the College of Physiotherapy of Alberta (CPTA).

Name: _____ Date: _____

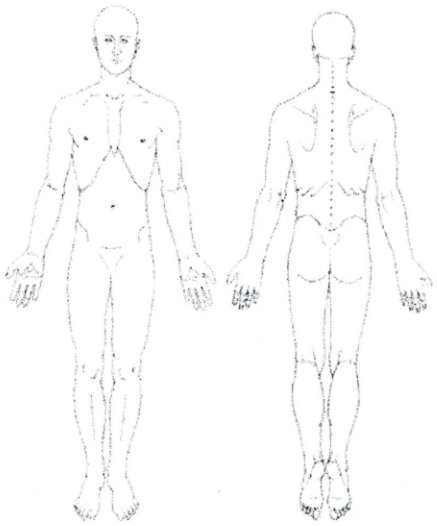
Signature: _____

PHYSIOTHERAPY ASSESSMENT

NAME: AGE:

DATE:

HISTORY:



SYMPTOM BEHAVIOR:

- CONSTANT - INTERMITTENT

TYPE OF PAIN:

AGG:

EASE:

SLEEPCHANGE:

AM: PM:

CREPITUS:

NUMBNESS / TINGLING

HEADACHE / NAUSEA / DIZZINESS

PAIN SCALE:

COUGH / SNEEZE:

MEDS:

FURTHER TESTS:

GENERAL HEALTH:

DOMINANT H/L:

REC ACTIV:

PROVISIONAL DIAGN: