Muscle & Joint Clinic

First Name: ______________________ Last Name: ______________________

Date of Birth (dd/mm/yy) _____/______/_______ Age: __________ Height: ________ Weight: _________ Gender: ☐ M ☐ F

Address: ______________________ City: ______________________

Postal Code: _____________ Home Ph: ______________________ Cell : ______________________

Email: ______________________ How Did You Hear About Us? ______________________

Do you have extended health insurance? ☐ Yes ☐ No Occupation: ______________________

Does your spouse have extended health insurance? ☐ Yes ☐ No If Yes, spouse's date of birth: ______________________

☐ Great West Life
☐ Sunlife
☐ Blue Cross
☐ Green Shield
☐ Desjardins

☐ Industrial Alliance
☐ Standard Life
☐ Equitable Life
☐ Claim Secure
☐ Manulife

☐ Other

Policy Number: ______________________

Group ID: ______________________

30 minute massage $60

45 minute massage $75

60 minute massage $90

90 minute massage $130

*Hst Applicable To Massage Fees

- All fees are due at time of service and It is the patient's or guardian's responsibility to ensure the clinic is fully compensated for all services rendered.
- A 48-hour cancellation policy is in effect. Failure to show up for a scheduled appointment or arriving 30-minutes late will result in a no show fee equal to the visit fee will be added to the patient's account.
- Accounts over ninety days may be subject to collections and a twenty-five percent service fee.
- All insurance related information collected by our clinic can not be guaranteed to be accurate. Please contract your insurance company directly for accurate information in regards to your insurance plan.
- If your care is the result of a work injury or auto injury, the patient is still responsible for all outstanding fees owing to the clinic for services rendered.

If you have read and agree to the clinic fees and policies above please sign below:

Sign Here: ______________________

4-5980 Churchill Meadows Blvd, Mississauga, ON L5M 7M5

What is your primary health concern: ____

____

Have you had massage therapy before: ☐ Yes ☐ No

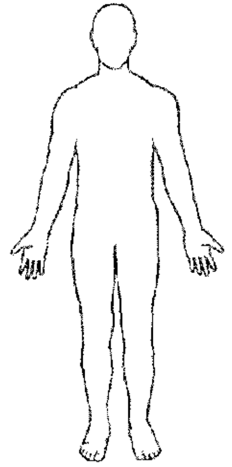
Are you seeing another health practitioner? ☐ Yes ☐ No

If yes, whom are you seeing?____

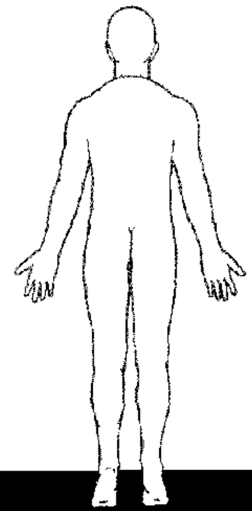
Are you on any medications? ☐ Yes ☐ No If yes, please list below:

Please List Any Medication You Are Taking		Please List Any Surgeries You Have Had
Name	Reason	

Therapist Notes:



Front



Back

Please indicate all conditions you have experienced:

Joint/ Soft Tissue Discomfort
- ❑ Neck
- ❑ Back
- ❑ Shoulders
- ❑ Legs: Right/ Left
- ❑ Knees: Right/ Left
- ❑ Feet: Right/ Left
- ❑ Arms: Right/ Left
- ❑ Hands: Right/ Left
- ❑ Osteoarthritis
- ❑ Rheumatoid Arthritis
- ❑ Degenerative Discs
- ❑ Sciatica

Other
- ❑ Loss/ Altered Sensations
- ❑ Cancer
- ❑ Diabetes
- ❑ Hemophilia
- ❑ Mental Illness
- ❑ Osteoporosis
- ❑ Artificial Limbs
- ❑ Artificial Joints
- ❑ Internal Rods, Pins, Wires or Special Equipment
- ❑ Epilepsy
- ❑ History of Transient Ischemic Attacks
- ❑ Multiple Sclerosis
- ❑ Parkinson's
- ❑ Skin Conditions
- ❑ Allergies/ Hypersensitivities

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Digestive
- ❑ Belching/ Gas
- ❑ Constipation
- ❑ Diarrhea
- ❑ Poor Appetite
- ❑ Ulcer
- ❑ Vomiting

Infections
- ❑ Hepatitis
- ❑ TB
- ❑ HIV/ AIDS
- ❑ Herpes

Women
- ❑ Heavy Flow
- ❑ Irregular Cycle
- ❑ Menopausal
- ❑ Painful Menstruation
- ❑ Pre-menopausal
- ❑ Pregnant (due date:___________)

Respiratory
- ❑ Shortness of breath
- ❑ Chronic Cough
- ❑ Breathing problems
- ❑ Smoker
- ❑ Asthma
- ❑ Pneumonia
- ❑ Bronchitis

Head/ Neck
- ❑ History of headaches
- ❑ History of migraines
- ❑ Vision Loss
- ❑ Hearing Loss
- ❑ Sinus Infection
- ❑ Swollen Glands

Cardiovascular
- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Coronary Heart Disease
- ❑ Heart Attack
- ❑ Phlebitis/ Varicose Veins
- ❑ Pacemaker/ similar
- ❑ Palpitations
- ❑ Stroke
- ❑ Poor Circulation
- ❑ Chronic Congestive Heart Failure

Family History:

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YOUR PRIVACY IS OUR PRIORITY

Patient Consent Form For Collection, Use and Disclosure of Personal Information

In this office, for their respective patients, Dr. Faisal Malik acts as the Privacy Information Officer. 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 use and protection of your information. Attached to this consent form, we have outlined what our office is doing to ensure that: Only necessary information is collected about you; Information is shared only with your consent; storage, retention and destruction of your personal information complies with existing legislation, and privacy protection protocols; Our privacy protocols comply not only with privacy legislation, but with the standards of the Ontario Chiropractic Association, and the law. Do not hesitate to discuss our policies with Dr. Faisal Malik or any member of our office staff. Please be assured that every staff member in our office is committed to ensuring that you receive the best quality health care. This office will collect, use and disclose information about you for the following purposes: To offer and provide treatment, care and services for all chiropractic health care issues. To deliver safe and efficient patient health care and to identify and ensure continuous high quality service. To assess your health care needs and to advise you of treatment options. To enable us to contact you and maintain communication with you, for purposes of distributing health care information and booking/confirming appointments for treatments. To maintain communication with you through email newsletters. To invoice for goods and services, to process credit card payments, and to collect on unpaid accounts. To communicate with other treating health care providers, including your pharmacist/pharmacy. To communicate with laboratories in cases where laboratory services are required. For teaching and demonstrating purposes on an anonymous basis. To complete and submit chiropractic claims for third party adjudication and payment. To comply with legal and regulatory requirements, including the delivery of patients' charts and records to the Ontario Chiropractic Association in a timely fashion, when required, according to the provisions of the Personal Health Information Protection Act (PHIPA) . To comply with agreements/undertakings entered into voluntarily by the member with the Ontario Chiropractic Association, including the delivery and/or review of patients' charts and records to the Association in a timely fashion for regulatory and monitoring purposes. To deliver your charts and records to the Chiropractic insurance carrier to enable the insurance company to assess liability and quantify damages, if any. To assist this office to comply with all regulatory requirements and to comply generally with the law By signing the consent section of the 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 that are 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 Personal Health Information Protection Act (PHIPA) for the purposes of the Ontario Chiropractic Association fulfilling its mandate under the PHIPA, and for the defense of a legal issue. Our office will not, under any condition, supply your insurer with your confidential medical history. In the event that this kind of a 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 inappropriate. You may withdraw your consent for use or disclosure of your personal information at any time, and we will explain the ramifications of the decision, and the process.
Patient Consent

I have reviewed the Privacy Policy that explains how this office will use my personal information, and the steps this office is taking to protect my information. I know that this office has a Privacy Policy, and I can ask to see the Policy at any time. I agree that Dr. Faisal Malik and his staff can collect, use and disclose personal information about myself as set out in the attached information about the office's privacy policies.

Signature: ____ Date (dd/mm/yy): ________/________ /__________

Massage Therapy
Informed Consent Form

I hereby request and consent to therapeutic massage treatments on me by the Registered Massage Therapist.

I understand and am informed of the benefits of massage therapy, as well as the possible side effects, risks, and the consequences of not having such treatment. I further understand that I do not expect the Massage Therapist to be able to anticipate and explain all risks and complications, and I wish to rely on the Therapist to exercise judgment during the course of the treatment, which the Therapist feels at the time, based upon the facts then known to be in my best interest. All female patients must inform the massage therapist if they know or suspect that they are pregnant.

I have had the opportunity to ask questions and I am aware of my right to modify or stop the assessment/treatment at any time and/or refuse, alter or withdraw this consent at any time. Treatment times include assessment time; time spent getting on and off of the massage table, and remedial exercise if required. I understand that payment for services received is my responsibility and must be made at time of service. If my claim is to be submitted directly to an outside agency for payment, and for some reason the third party payer denies the claim and/or refuses to pay all or partial the full amount billed, I am responsible for paying the amount outstanding.

I am aware of the cancellation policy that requires 48 hours notice to cancel a massage appointment. Appointments that are missed will be billed a missed appointment fee (50% of full price).

I intend this consent to apply to all my present and future Massage Therapy visits.

Dated this___________ day of_______________________(month), 20_________.

Patient Signature (Legal Guardian): ______________________________

Patient Name (Please Print): ____________________________________

Signature of Witness ____

Witness Name (Please Print)____________________________________

Muscle & Joint Clinic

Consent for Assessment and Treatment of Sensitive Areas

I, ___________________________________, have requested assessment/ treatment by this Registered Massage Therapist (RMT), ________________________________.

As part of my therapeutic assessment and treatment, I am aware that the above named RMT will assess/ treat the following area(s) of my body.

[Breast(s), Chest wall muscles, Inner thighs, Buttocks]

Area(s) to assess/treat : ____
Initials: ________________

The RMT has explained the following to me and I fully understand the proposed assessment and treatment, including:

- The nature of the assessment and/or treatment, including the clinical reasons to assess/ treat the above area(s) and the draping methods to be used
- The expected benefits of the assessment and/or treatment
- The potential risks of the assessment and/or treatment
- The potential side effects of the assessment and/or treatment
- That consent is voluntary and I can withdraw or alter my consent at any time

Initials: ________________

I voluntarily give my informed consent for the assessment and/or treatment as discussed and outlined above.

Client's name: ____

Client's signature: ____

Date: ____

RMT signature: ____

Clinical Indication: ____