Phone: 416.699.0368
Website: www.quarrychiropractic.com
Email: info@quarrychiropractic.com

PHYSIOTHERAPY

Service:	Patient Fee:
Physiotherapy Initial Consultation	**$90.00**
Subsequent Visit	**$60.00**
Re-evaluation re: **90+ days** since last treatment	**$70.00**

WE ACCEPT: CASH, CHEQUE, INTERAC, VISA, MASTERCARD

The Quarry Chiropractic Clinic does not third party bill (i.e. bill your insurance on your behalf), therefore fees recoverable from extended health benefits are the patients own responsibility. **It is the policy of the Quarry Chiropractic Clinic that payment is required at the time of services rendered. No accumulation of fees is permitted.**

NOTE: IF MORE THAN 3 APPOINTMENTS ARE MISSED WITHOUT NOTIFYING THE OFFICE 24 HOURS IN ADVANCE YOU WILL BE CHARGED $50 FOR A MISSED VISIT ALONG WITH YOUR NEXT TREATMENT FEE.

Receipts / Statements for services, when would you like it?

A receipt each visit: ______________ When I ask for one: ______________

End of each month: ______________ December 31st: ______________

Please note that it is the sole responsibility of the patient to provide payment on any denied insurance claims. By signing this document, you agree to pay in full any amount owing for services rendered in the event that your claim is denied by the insurance company.

Name:______________________________

Date: ______________ **Signature:** ______________________________

Quarry Chiropractic Clinic - 2560 Gerrard Street East #103, Scarborough ON M1N 1W8
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The data on this confidential form is essential if we are to tender the best professional care. We appreciate your co-operation in filing it out so that we will have accurate records. PLEASE PRINT CLEARLY – THANK YOU

Name: ____ Sex: M / F

Home address: ____

City / Town: ____________________________ Postal code: ______________

Home Phone: ______________________ Business: ______________________

Cell☐ / Pager ☐ ______________________ Referred by: ______________________

Email address: ______________________ Occupation: ______________________

Date of Birth: day: ________ month: _______ year: _______

Family Doctor: ______________________ phone #: ______________________

Referring Specialist: ______________________ phone #: ______________________

Is this visit due to a Motor Vehicle Accident (MVA)? Yes ☐ No ☐

Is this a WSIB case and has it been reported to your employer? Yes ☐ No ☐

Please list any medications that you are currently taking or have taken in the past year:

____

____

____

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Condition	Y N Pacemaker	Y N Rheumatoid Arthritis	Y N Hepatitis	Y N Anemia
Y N High/ Low Blood Pressure	Y N Alcohol/ Drug Abuse	Y N Sinus Problems	Y N Glaucoma	Y N Kidney Problems
Y N Ulcers/ Colitis	Y N Cancer	Y N Anticoagulants	Y N Severe/ Frequent Headaches	Y N Tuberculosis
Y N Difficulty Breathing	Y N Psychiatric problems	Y N Diabetes	Y N Emphysema/ Asthma	Y N Arthritis
Y N Are you pregnant	Y N Fainting/ Seizures/ Epilepsy	Y N Stroke	Y N Artificial Bones/ Joints/ Implants	Y N Allergies
Y N Hearing loss	Y N Peripheral vasucular disease	Y N Depression/Anxiety	Y N Hemophilia	

Please list any surgeries with dates and/ or any other serious medical condition(s) not listed above:

____

____

____

Have you had any recent unexplained weight loss or have been feeling generally fatigued or unwell?________________________

____

Have you ever had any fractures or dislocations?____

____

Do you have any areas where you lack sensation or have decreased sensitivity to hot or cold? _____________________________

____

Do you have any open wounds or areas of infection?____

____

List any past serious accidents with dates: ____

____

- We invite you to discuss with us any questions regarding our services. The best services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.
- I understand the benefits of collaboration between my health care providers. If I were to be under the treatment/care of more than one staff member of the Quarry Chiropractic Clinic, then I authorize collaboration between parties to provide me with the best care possible.

Name____

Signature ____ Date ______________________________

☐ Adult patient ☐ Parent or Guardian ☐ Spouse