*All information is considered confidential.*

NAME: ______________________________ DATE: ________________________ GENDER: M / F / X

DATE OF BIRTH: *dd /mm /yyyy* ____________ ALBERTA HEALTH CARE #: __________________________

ADDRESS: ____________________________ CITY: ____________________ POSTAL CODE: __________

PHONE: (H) ____________________ OCCUPATION: ____________________________________

(W) ____________________ EMAIL: ____________________________________________

(C) ____________________ *Do you consent to confirmations or updates via email? YES / NO*

Emergency Contact: ______________________________ Phone: ____________________________

Family Doctor: __________________________________ Phone: ____________________________

How did you hear about our clinic?

______________________________________________________________________________

**Is the reason you came to this clinic related to a:**

A) Motor Vehicle Accident? YES / NO Date of loss: dd /mm /yyyy __________

B) WBC Claim? YES / NO Date: dd /mm /yyyy ______________

*Fee schedule:*

| CHIROPRACTIC | Adult | Child (16 and under) |
|---|---|---|
| Initial Assessment | $100 | $65 |
| Treatment (Adjustment only) | $50 | $40 |
| Treatment + Neuromuscular | $75 | $65 |
| Treatment + ART® | $75 | $65 |
| Treatment + Laser | $75 | $65 |
| Treatment + Decompression | $100 | $100 |

| MASSAGE THERAPY | |
|---|---|
| 30 min | $60 |
| 45 min | $75 |
| 60 min | $95 |
| 90 min | $126 |

| PHYSIOTHERAPY | |
|---|---|
| Initial Assessment | $100 |
| Physio Follow Up | $65 |
| IMS Assessment | $120 |
| IMS Follow Up | $90 |
| Two Body Part Assessment | $140 |
| Two Body Part Follow Up | $120 |

| SPINAL DECOMPRESSION | |
|---|---|
| One Body Part | $100 |
| Neck + Back | $150 |

**SHOCKWAVE THERAPY (ESWT)**

$75-150

*Insurance Information:*

We direct bill most insurance companies (Alberta Blue Cross, Chamber of Commerce Group, Cowan, CINUP, Desjardins, Equitable Life, Great West Life, Green Shield, Industrial Alliance, Johnson INC, Manulife Financial, Maximum Benefit or Johnston Group, MVA, RCMP, RWAM, Standard Life, Sun Life Financial, and Veterans Affairs).

**Would you like us to direct bill for our services? YES / NO Please provide reception with card information.**

I hereby assign benefits payable for the eligible claims to the Provider responsible for submitting my claims electronically to the groups benefit plan, and I authorize the insurer/plan administrator to issue payment directly to the Provider.
In the event my claim(s) are declined, I understand that I remain responsible for payment to the Provider.

Please Initial

**Payment is required at time of treatment unless other arrangements have been made.**
**At all times, you are responsible for the balance of your account.**
**We appreciate 24 hours notice when cancelling or rebooking appointments.**
*I, the undersigned, have read the above statements and agree to them for the term of my care.*

Please Initial

SIGNATURE: ______________________________ DATE: *dd /mm /yyyy* __________

# Electronic Transmission Authorization and Consent Form

Instructions: This form must be filled out when claims are submitted electronically by the provider on the patient's behalf. Please retain this form in the patient's file for verification purposes for two years following closure of the patient file.

## Consent to Collect and Exchange Personal Information

Message to the Plan Member, Spouse and/or Dependent regarding Personal Information

Personal information that we collect and disclose about you, and if applicable, your spouse and/or dependents is used by the insurer and/or plan administrator and their service provider(s) for the purposes of assessing your claims, underwriting, investigating, auditing and administering the group benefits plan, including the investigation of fraud and/or plan abuse.

## Authorization and Consent

I authorize my healthcare provider to collect, use and disclose personal information concerning any claims submitted on my behalf with the insurer and/or plan administrator and their service provider(s) for the above purposes.

I authorize the insurer and/or plan administrator and their service provider(s) to:

- Use my personal information for the above purposes
- Exchange personal information with any individual or organization, including healthcare professionals, investigative agencies, insurers and reinsurers, and administrators of government benefits or other benefits programs when relevant for the above purposes.
- Exchange personal information concerning any claims submitted with the plan member or a person acting on behalf of the plan member.
- Exchange personal information for the above purposes electronically or in any other manner.

I understand that personal information may be subject to disclosure to those authorized under applicable law.

I agree that a photocopy or electronic version of this authorization shall be as valid as the original and may remain in effect for the continued administration of the group benefits plan.

## Additional Consent Applicable to Plan Members Only

I confirm that I am authorized by my spouse and/or dependents, if any, to disclose personal information about them to the insurer and/or plan administrator and their service provider(s) for the purposes described above and I confirm that my spouse and/or dependents also authorize the insurer and/or plan administrator and their service provider(s) to disclose information about their claims to me, for the purposes of assessing and paying a benefit, if any, and managing the group benefits plan. I also authorize my spouse and/or dependents to assign benefit payments under the plan to the healthcare provider.

In the event there is suspicion and/or evidence of fraud and/or plan abuse concerning claims submitted, I acknowledge and agree that the insurer and/or plan administrator and their service provider(s) may use and disclose relevant personal information to any relevant organization including lay enforcement bodies, regulatory bodies, government organizations, medical suppliers and other insurers, and where applicable my Plan Sponsor, for the purposes of investigation and prevention of fraud and/or plan abuse.

If there is an overpayment, I authorize the recovery of the full amount of the overpayment from any amount payable under the group benefits plan, and the exchange of personal information with other persons or organizations, including credit agencies and, where applicable, my Plan Sponsor, for that purpose.

Company______________________ Policy/Plan ____________________ ID/Certificate ________________________

Date ___________________________ Signature ________________________________