



Office Policies

Welcome to WAKE Wellness,

It is our optimal goal to provide you and your family with the highest quality of care, while maintaining a friendly and relaxing environment. To keep our standard of care to a level which best serves your needs, we ask that you please observe the following guidelines:

If an appointment must be changed, 24 hours' notice is required so that the practitioner may service others during that allotted time. Please let the receptionist know and changes will be made accordingly. If failure to provide notice occurs, you will be subject to a short-notice cancellation/missed appointment fee. For chiropractic care, it is recommended that any missed appointments be made up later in the same day or within 7 days to prevent loss of spinal correction.

Payment is due at the time of the office visit unless we are billing your extended health insurance, motor vehicle insurance or WSIB directly. Please let us know if you wish to pay by cash, debit, or credit (visa or MasterCard accepted). Receipts will be issued at the time of the visit or annually.

You will achieve the best results when you follow the practitioner's recommended appointment schedule and home care advice. Remember: healing takes time. If you do not feel satisfied with your body's responses, please discuss this with your practitioner. We want you to get the most from your care. Please speak with us if you have any concerns – your comments will help us to help others.

I _____ authorize my healthcare provider to collect, use and disclose personal information concerning any insurance claims submitted on my behalf with the insurer and/or plan administrator and their service provider(s) relating to my clinic visits and charges.

I recognize that when providing an email address on clinic intake forms, I am consenting to receive appointment reminder emails and the occasional newsletter or promotional email from WAKE Wellness.

I agree and consent to the above written terms.

Signature: _____

Date: _____

HEALTH HISTORY FORM

The information requested below will assist us in treating you safely. Feel free to ask any questions about the information being requested. If your health status changes in the future, please let us know.

Name: _____ Today's Date: _____ Birth Date(y/m/d): _____

Address: _____ Postal Code: _____

Phone(home) _____ (Cell) _____ (Work) _____

Email: _____ Occupation: _____

How did you hear about us? _____

Have you had massage before? Y N If so, when was your last massage? _____

Please indicate conditions you are experiencing or have experienced.

<p>Cardiovascular</p> <ul style="list-style-type: none"> <input type="checkbox"/> high blood pressure <input type="checkbox"/> low blood pressure <input type="checkbox"/> chronic congestive heart failure <input type="checkbox"/> heart attack <input type="checkbox"/> phlebitis/varicose veins <input type="checkbox"/> stroke/CVA <input type="checkbox"/> pacemaker/similar device <input type="checkbox"/> heart disease <p>Is there a family history of any of the above? Yes ____ No ____</p> <p>Infections</p> <ul style="list-style-type: none"> <input type="checkbox"/> hepatitis <input type="checkbox"/> TB <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> skin conditions _____ (eg. psoriasis, eczema) 	<p>Respiratory</p> <ul style="list-style-type: none"> <input type="checkbox"/> shortness of breath <input type="checkbox"/> bronchitis <input type="checkbox"/> asthma <input type="checkbox"/> emphysema <input type="checkbox"/> chronic cough <p>Is there a family history of any of the above? Yes ____ No ____</p> <p>Other Conditions</p> <ul style="list-style-type: none"> <input type="checkbox"/> loss of sensation _____ <input type="checkbox"/> diabetes (onset: _____) <input type="checkbox"/> allergies/hypersensitivities <input type="checkbox"/> epilepsy <input type="checkbox"/> cancer _____ <input type="checkbox"/> arthritis _____ <p>Is there a family history of arthritis? Yes ____ No ____</p>	<p>Head / Neck</p> <ul style="list-style-type: none"> <input type="checkbox"/> history of headaches <input type="checkbox"/> history of migraines <input type="checkbox"/> vision problems <input type="checkbox"/> vision loss <input type="checkbox"/> ear problems <input type="checkbox"/> hearing loss <p>Women</p> <ul style="list-style-type: none"> <input type="checkbox"/> pregnant-due date _____ <input type="checkbox"/> gynaecological conditions <p>In General</p> <p>Overall, how is your general health? _____</p> <p>Primary Care Physician: _____</p> <p>Address: _____</p>
<p>Current medications and the conditions they treat: _____ _____ _____</p> <p>Are you currently receiving treatment from another health care professional? Yes ____ No ____ If yes, for what? _____</p> <p>Surgery – date: _____ nature: _____</p> <p>Injury – date: _____ nature: _____</p>	<p>Do you have any other medical conditions? (eg. Digestive conditions, haemophilia, osteoporosis, mental illness) Yes ____ No ____ If yes, what? _____</p> <p>Do you have any internal pins, wires, artificial joints or special equipment? Yes ____ No ____ If yes, what? _____ _____ where? _____</p> <p>What is the reason you are seeking massage? _____ _____ _____</p>	



The Collection, Use and/or Disclosure of Personal Information

WAKE Wellness only collects information relevant to the services we provide and has a comprehensive privacy policy in accordance with the current Federal and Provincial privacy legislations, the standards of our regulatory body, The College of Massage Therapists of Ontario (CMTO), the Massage Therapy Act, and the Regulated Health Professions Act.

At WAKE Wellness, the Health Information Custodian (HIC) is sanctioned to the registered massage therapist who performs the initial assessment.

Why does WAKE Wellness need to collect, use and/or disclose your Personal Information?

- To provide safe and efficient treatments through a baseline of health information
- To advise you of treatment options and/or communicate with other regulated health professionals in your "circle of care"
- To allow WAKE Wellness to contact you
- To invoice for goods and services and collect unpaid accounts
- To comply with The CMTO who conduct regular inspections across the province

How will WAKE Wellness protect your Personal Information?

- Information is either supervised or secured in a locked area
- Staff and volunteers are trained in accordance with our privacy policy
- External agencies must enter privacy agreements with us
- Files are kept for at least 10 years after last appointment with us
- Paper information is destroyed by shredding

Consent for the Collection, Use and/or Disclosure of Personal Information

I have reviewed this information sheet explaining how and why WAKE Wellness will collect, use and/or disclose my personal information. If I need more information there is a Privacy Policy I can read at any time, which addresses these issues in detail. You can also contact the *Information and Privacy Commissioner/Ontario* at 2 Bloor Street East, Ste. 400, Toronto, Ontario M4W 1A8; Tel.: 1-800-387-0073; email: info@ipc.on.ca

By signing this Consent I agree to the collection, use and/or disclosure of my personal information for the purposes listed above and to the cancellation policy below.

Cancellation Policy

Please be advised that WAKE Wellness requires **24hrs** notice for cancelled appointments. Appointments missed without notification will be billed accordingly.

Printed Name: _____ Signature: _____