

## **WELCOME!!**

Welcome to our clinic! We are delighted to have you as a new patient and we look forward to providing you with the highest quality care.

### **FEES**

**Regular Fees/Without Assistance:** The initial visit is **\$55.00**; subsequent visits are **\$40.00**.

**Premium Assistance:** The Medical Service Plan may subsidize up to ten (10) visits per calendar year to those who qualify for premium assistance. For those who qualify (please inquire with the front desk with your care card number) the initial user fee is **\$25.00**; nine (9) subsequent visits are **\$15.00**. For every visit thereafter, the fee is \$40.00.

**ICBC:** Initial visit is **\$30.00**; each visit thereafter is **\$25.00**.

**WCB:** There is no user fee (**\$0.00**) if your claim is accepted by WCB.

**The above fees may be reimbursed by your extended benefit plan.**

### **PAYMENT OPTIONS**

You have the option of paying cash, Interac, cheque, MasterCard, Visa or AMEX.

### **SCHEDULING AND CANCELLATION POLICY**

Dr. Parsons will recommend a treatment program for your recovery. If you have preferences for certain times, we suggest you schedule them in advance. We require a minimum of 24 hours notice if you must cancel your appointment. If you miss an appointment, or fail to notify us in advance, a \$20.00 missed appointment fee will apply.

Please be advised some patients may be sensitive to perfumes and colognes.

**I have read and agreed to the above policy.**

**Signed** \_\_\_\_\_

**Dated** \_\_\_\_\_

**Please fill out the reverse of this form.**

Confidential New Patient Information

Name \_\_\_\_\_ Employer \_\_\_\_\_
Address \_\_\_\_\_ Postal Code \_\_\_\_\_ Date of Birth \_\_\_\_\_
Home Phone \_\_\_\_\_ Work/Cell Phone \_\_\_\_\_ Care Card \_\_\_\_\_
Family Doctor \_\_\_\_\_ May we forward a clinical progress note to your family doctor? Yes/No
Is This an I.C.B.C./W.C.B. claim? If Yes, Date of accident \_\_\_\_\_ I.C.B.C./W.C.B. claim # \_\_\_\_\_
Extended Health Care Provider \_\_\_\_\_ Client/Plan Number \_\_\_\_\_
E-mail address \_\_\_\_\_ Who referred you to this clinic? Yellow Pages/Doctor/Friend \_\_\_\_\_
Have you ever received Chiropractic Care? Yes/No If yes, Doctor's name/when & why \_\_\_\_\_

1. Reasons for seeking care today:

2. Location of Complaint: Use drawing ----->

- A = ACHE S = STABBING
P = PINS & NEEDLES N = NUMBNESS
B = BURNING O = OTHER

Complaint began when and how? \_\_\_\_\_

Do you have any numbness or tingling in your body? Where? \_\_\_\_\_

Intensity (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Most pain)

How frequent is the complaint present and how long does it last? \_\_\_\_\_

Does anything aggravate the complaint? Make it better? \_\_\_\_\_

Previous treatments, medications, surgery, or care you've sought for your complaint: \_\_\_\_\_

Current or previous illnesses you've had in your life: \_\_\_\_\_

Previous injuries, traumas or broken bones: \_\_\_\_\_

Medications & reason for taking, Allergies: \_\_\_\_\_

Surgeries: \_\_\_\_\_

Are there any illnesses that run in your family? \_\_\_\_\_

Chiropractic doctors are required to advise patients of the nature of the treatment to be provided, the risks and benefits of the treatment, and any alternatives to treatment. There are risks and possible risks associated with manual therapy techniques used by doctors of chiropractic. In particular you should note:

- a) While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures;
b) There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustments is extremely remote;
c) There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or other chiropractic treatment;
d) There are infrequent reported cases of burns or skin irritation in association with the use of some types of electrical therapy offered by some doctors of chiropractic.

I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general, (including spinal adjustment), the treatment options and recommendations for my condition, and the contents of this Consent.

I consent to the chiropractic treatment recommended to me by my chiropractor including any recommended spinal adjustments.

I intend this consent to apply to all my present and future chiropractic care.

Patient (or Legal Guardian) Signature \_\_\_\_\_ Date: \_\_\_\_\_

