

2018 Office Policy and Fee Schedule

Chiropractic Services are NOT covered by OHIP

Insurance: Chiropractic services and products are covered under most extended health insurance plans. Payment for Chiropractic services and or products are expected in full after each visit. Details of your insurance coverage is your responsibility. Please contact your insurance provider with questions regarding your coverage. Co-payments and or deductibles with your insurance provider are your responsibility. You are responsible for any unpaid balance for Chiropractic services and or products that are unpaid by your insurance provider.

Assignment of Benefits: If you elect to have your insurance provider assign your benefits to Mount Joy Foot Clinic & Orthotic Centre, you certify that you (or any dependents) have coverage with an insurance provider as presented and assign payment directly to Mount Joy Foot Clinic & Orthotic Centre for all services rendered and products dispensed. Any unpaid balances will be processed to the pre-authorized method of payment on file.

Fees: Fees for our products and services are subject to change without prior notice. Please refer to our fee guide for detailed pricing of our products and services.

PATIENT INFORMATION

First Name _____ Last Name _____ DATE OF BIRTH (MM/DD/YYYY) ____/____/____

Address _____ Apartment # _____ City/Town _____ Postal Code _____

Home Phone # _____ Mobile Phone # _____ E-mail _____

Emergency Contact Name _____ Relationship _____ Emergency Phone # _____

Parent/Guardian Name (if patient is under 16 years of age): _____

HOW DID YOU HEAR ABOUT THE MOUNT JOY FOOT CLINIC & ORTHOTIC CENTRE?

Family / Friend Name: _____ Yellow Pages Doctor Referral; Name: _____

Google Yahoo Yelp Lakeview Magazine Other – Please list: _____

PLEASE ANSWER THE FOLLOWING FOOT HEALTH RELATED QUESTIONS

Your primary complaint involves: Right foot Left foot Other Explain: _____

How long have the symptoms been present? 0 to 8 weeks 2 to 6 Months 6 to 12 months 1 year +

Is your foot related problem getting? Worse Better No change

Have you been treated for any of the following? (Check all that apply)

- Flat feet Corn(s) / Callus Plantar wart(s) Toenail fungus Athletes foot
 Heel pain / plantar fasciitis Ingrown toenail(s) Bunion(s) Hammer toe(s) Cracked heels / Dry skin
 Arch pain Ankle injury / pain Knee / Back injury / pain Ball of foot injury / pain Neuroma

Have you ever worn custom foot orthotics? Yes No **What is your current?** Height ____' ____" Weight _____ lbs / Kg, Shoe Size: _____

PATIENT MEDICAL HISTORY

Please list your **current medications:** _____

Family doctor name _____ Consent to contact family doctor as part of treatment plan? Yes No

Have you been treated for any of the following? (Please mark all that apply)

- Angina / Chest pain Anxiety Asthma Cancer Congestive heart failure
 Depression Diabetes (Type 1 / Type 2) Digestive disorder Eczema Emphysema
 Epilepsy Heart Attack Hepatitis High blood pressure High cholesterol
 HIV / AIDS Kidney disease Liver disease Osteoarthritis Poor circulation
 Psoriasis Rheumatoid arthritis Shortness of breath Stroke / CVA Thyroid disorder (Hypo / Hyper)
 Urinary trouble Other: _____

Allergies (Please list all known) _____ **Are you pregnant / breast feeding?** Yes No

PATIENT CONSENT AND AUTHORIZATION FOR CHIROPODY TREATMENT

I acknowledge that all the above information is correct. I understand that this information is confidential and will be used for no other purpose than for the Chiropractor(s) clinical record.

I hereby give consent to the examination and treatment by the Chiropractor(s) and or his associate(s) and allow photographs only of the treatment area for documentation and monitoring purposes. I consent the Chiropractor to send my physician or health care professional a report regarding my foot exam and treatment plan only when necessary. I understand that I am financially responsible for all charges whether covered by my health insurance plan or not. I understand that service and product fees are payable at the time service is provided or products are dispensed.

PATIENT SIGNATURE (Parent / Guardian if under 16) X _____ **DATE** (MM/DD/YYYY) _____