Welcome to A Body In Motion Rehabilitation!
Please take a few moments to complete the information below and please carefully read and sign the back of this form. Thank you!

Name: _____
Address: _____
Telephone Number: (Home) _____(Cell): _____ (Work): _____
Email Address: _____
Family Physician (Name and Telephone No): _____

Who can we thank for referring you to ABIM? _____

Your Date of Birth (dd/mo/yr): _____
Date of Your Injury (dd/mo/yr): _____

Health Card Number (to obtain test results only): _____
Current Medications: _____

Have you ever experienced or are you currently experiencing any of the following (check only those that apply):

Diabetes ☐
Heart Disease ☐
Kidney Disease ☐
Dizziness/Vertigo ☐
Do you have a pacemaker ☐
Hernia ☐

High Blood Pressure ☐
Epilepsy ☐
Cancer ☐ Type: _____
Nervous Disorders: ☐
Migraines/Chronic Headaches ☐
Are you currently Pregnant ___ weeks

Previous Surgeries: _____
Allergies: _____
Are there any other conditions that you are medically followed for? _____

Once again, we would like to welcome you to ABIM. We look forward to working with you and thank you for choosing us to assist you in your healing. We have a few recommendations to enhance your experience.

1) We ask that you wear comfortable clothing that will allow you to move freely and that will allow us to view the body part that we will be assessing and treating.
2) Please ensure that your appointments are scheduled and that you receive written confirmation of these appointments. Email reminders are a courtesy. We ask that you remain aware of your schedule
3) Please be on time for your appointment. Your physiotherapist will dedicate the initial 20 minutes of your appointment to hands on therapy. If you are late, manual therapy time is decreased so please be prompt.
4) **24 hours notice is required to cancel a physiotherapy appointment.** If 24 hours is not provided, you will be charged the full price of the appointment. ***Initial:*** ____

FEES FOR SERVICE AND PAYMENT RESPONSIBILITY
A Body In Motion Rehabilitation is a privately owned and operated clinic and we do not receive OHIP funding. Clients are responsible for payment of all services received. Fees for service are as follows:

Vestibular Physiotherapy
Initial Assessment $110.00
Follow Up Visit $95.00

Telerehab Vestibular Physiotherapy
Initial Assessment $110.00
Follow Up Visit $95.00

To ensure that you have understood the fees and payment scheduled, please read and sign the following:

I, _____ understand that I am responsible for the payment of all professional services that I receive at A Body In Motion Rehabilitation. It is my responsibility to pay my invoices when they are presented to me and it is my responsibility to submit my receipts for reimbursement from my extended healthcare provider. I understand that the payment is due on the day of service unless otherwise stated by the owner and that overdue accounts may be forwarded to a collection's agency where a 35% processing/interest fee will be added to the balance owing. **Signature**: _____

The injury that I am seeking treatment for did not occur within my workplace. I have not and do not intend to initiate a WSIB Claim for this injury. I understand and accept that if I do initiate a WSIB Claim in the future, A Body In Motion does not treat WSIB patients and will not reimburse payments made while you were a private patient at our clinic.
Signature: _____

****INFORMED CONSENT AND MEDICAL RELEASE****
I hereby authorize the representatives of A Body In Motion Rehabilitation to obtain and review copies of any hospital, medical or other related health records. I give permission for those same representatives, to discuss and to release valid, health related information to other health professionals or insurance representatives who may be involved in my rehabilitative care.
Signature: _____

TIME ALLOTMENT FOR TREATMENT
A reminder that when you are visiting us for the completion of an initial assessment, we are able to thoroughly assess one body part in the allotted time. Our goal is to provide you with the best possible care and compiling treatment will take away from your healing and increased the time frame required for your therapy. We thank you for your understanding
Signature: _____

I have carefully read through this intake sheet and have been given the opportunity to ask questions or to seek clarification. I acknowledge that all the information that I have provided is true and accurate.

Signature: _____ Date: _____