Coastal
Sports & Wellness

P 902-404-8034
F 902-406-7221
info@coastalsportsandwellness.com

Client Information

Name:____ Date:______________________

E-mail:____ DOB: ____/____/____
D M Y

Do you give permission to receive reminders of your appointments? **EMAIL?** YES NO
TEXT? YES NO
Name of MOBILE **Provider** for **TEXTS:** ______________________ **BOTH?** YES NO

Address:____

City/Prov:____ Postal Code:__________________

Phone #:(Hm)____________________ (Cell)____________________ (Wr)____________________

Occupation:____

Medical Doctor:____

Insurance Carrier: ______________________________________

Policy #:__________________________________ ID #:__________________________________

Second Insurance Carrier: ______________________________ Policy Holder Name: _____________________

Relationship (spouse, parent, self, etc.): _____________________

Policy #:__________________________________ ID #:__________________________________

How did you hear about Coastal Sports & Wellness: ____

Which areas would you like treated?

□ Back □ Neck □ Face □ Scalp □ TMJ □ Arms □ Hands □ Legs □ Glutes □ Feet
□ Chest □ Abdomen

Pressure:

□ Mild □ Firm □ Deep

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Health History

Musculoskeletal

	PAST	CURRENT
Neck	☐	☐
TMJ	☐	☐
Shoulder	☐	☐
Arm	☐	☐
Wrist	☐	☐
Hands	☐	☐
Upper Back	☐	☐
Mid Back	☐	☐
Low Back	☐	☐
Hip	☐	☐
Knee	☐	☐
Ankle	☐	☐
Foot	☐	☐
Migraines	☐	☐
Headaches	☐	☐
Clench Teeth	☐	☐
Bite Plate		☐
Joint Stiffness	☐	☐
Joint Swelling	☐	☐
Spasm/Cramps	☐	☐
Tendonitis	☐	☐
Bursitis	☐	☐
Herniated Disk	☐	☐
Spondylosis		☐
Scoliosis		☐
Osteoporosis		☐

Arthritis

Osteoarthritis ☐
where:________________________
Rheumatoid Arthritis ☐
where:________________________
Psoriatic Arthritis ☐
where:________________________

Allergies

Nuts ☐ Herbs ☐
Oils/Creams/ Lotions ☐
Aromas ☐ Enviro ☐
Latex ☐ Drug Allergy ☐
History of Anaphylaxis ☐
Other: ________________________

Motor Vehicle Accident

Date ___________________________

Injuries

(Breaks/Fractures/Sprains)

	Type	Year
1	______________________________	
2	______________________________	
3	______________________________	

Current Complications:
____
____

Respiratory/Circulatory

Chronic Cough ☐
Asthma ☐
Bronchitis ☐
Emphysema ☐
Other ☐

High Blood Pressure ☐
Low Blood Pressure ☐
Heart Condition ☐
Stroke/CVA ☐
Pacemaker ☐
Blood Clot ☐
Phlebitis/Varicose veins ☐
Other:________________ ☐

Skin

Infectious Condition ☐
Warts, Herpes ☐
Eczema ☐
Psoriasis ☐
Other ☐

Infectious Conditions

HIV/AIDS ☐
Hepatitis: ☐
type:_________________________
Tuberculosis ☐

Cancer

Type:_________________________
Year Diagnosed:________________
Chemotherapy ☐
Radiation ☐
Current Complications:
____

Special Considerations:

Pacemaker ☐ Artificial Joint ☐
Artificial valve ☐ Artificial Limb ☐
Med Patch ☐ Rods/Pins/Wires ☐
Implants ☐ Others ☐

Surgeries

	Type	Year
1	______________________________	
2	______________________________	
3	______________________________	

Current Complications:
____
____

Current Medications

Drug Name

1 _____________________________
2 _____________________________

Used For

1 _____________________________
2 _____________________________

Nervous/Digestive

Numbness/Tingling ☐
Where?____________________
Tinnitus ☐
Chronic Pain ☐
Cerebral Palsy ☐
Chronic Fatigue Syn. ☐
Fibromyalgia ☐
Multiple Sclerosis ☐
Parkinson's Disease ☐
Epilepsy ☐

Constipation ☐
Diarrhea ☐
Irritable Bowel Syn. ☐
Crohn's Disease ☐

Recurrent Infection ☐
Kidney Disease ☐

Prostate Problems ☐
Other:_____________ ☐

Diabetes

Type 1 ☐
Type 2 ☐
Year Diagnosed
____
Current Complaints:
____

Women

Pregnancy? ☐
Due:_________________ ☐
High Risk Pregnancy ☐
Endometriosis ☐
Breast Pain ☐
Breastfeeding ☐
Menstruation Issues ☐
Menopause Issues ☐
Other:_____________ ☐

Visual Impairment ☐
Hearing Impairment ☐

Life Style

Regular Exercise ☐
Types:______________________

Diet

Eating Habits:
Good ☐ Not Good ☐
Stress Levels:
High ☐ Medium ☐
Water Consumption per day:

Other Health Care:

	PAST	CURRENT
Physiotherapy	☐	☐
Chiropractic	☐	☐
Naturopathy	☐	☐
Osteopathy	☐	☐
Acupuncture	☐	☐
Massage	☐	☐

Reason for seeking massage:
____
____

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Informed Consent

I, ___________________________________ (client) acknowledge the benefits to Massage may improve circulation, increase relaxation, decrease muscular imbalances and pain, increase range of motion, decrease scar tissue and rehabilitate injuries. As well as any possible risks such as headache or nausea and any kickback pain that may be associated with the treatment.

I understand that Massage Therapists do not diagnose and is not replaceable medical treatment or medications, as well as high joint manipulations similar to chiropractic care.

I have notified the therapist of all medical conditions and medications, if any updates occur the therapist will be notified. Any pain or discomfort felt during treatment the therapist is to be notified immediately so modifications can be made to the treatment. This consent may be changed, modified or withdrawal at any time.

I also understand that if I cancel my appointment the DAY OF I will be charged a $30.00 fee. If I do not show for my appointment I will be expected to pay the FULL PRICE of the service I was scheduled for.

Signature:_____________________________________ Date:__________________________________
(if child under 18, guardian must sign)

Multidisciplinary Consent

All clients should be aware that Coastal Sports & Wellness may occasionally share with other health professionals in the clinic who are also treating the same client with information about your functional abilities and limitations, treatment modalities and active care programs to better communicate and provide the best treatment and recovery possible as a “team” approach. In keeping with our policy of obtaining your consent before speaking to anyone on your behalf, we ask that you read and sign the following:

I, ______________________________, Dated ___________________________________
hereby give my consent to Coastal Sports & Wellness to disclose my health information for the above purposes. Every effort will be made to ensure that my privacy will be respected at all times.

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Electronic Transmission Authorization and Consent & Benefit Assignment Form

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 the closure of the patient file.

PLEASE CHECK YOUR LOCATION:

- O 15 Dartmouth Rd, Suite 200
  Bedford, NS B4A 3X6
  902-404-8034
- O Mount Saint Vincent University – Assisi Bldg., 2nd Floor
  Halifax, NS B3M 2J6
  902-404-8034

Patient: ____

Consent to Collect and Exchange Personal Information

Message to the Plan member, Spouse, and/or Dependant regarding Personal information
Personal information that we collect and disclose about you, and if applicable, your spouse and/or dependants, is used by the insurer and/or plan administrator and they 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.

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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 law 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.

Benefit Assignment
I hereby assign benefits payable for the eligible claims to the Provider responsible for submitting my claims electronically to the group benefits plan and I authorize the insurer/plan administrator to issue payment directly to the Provider. In the event my claim(s) are declined by the insurer/plan administrator, I understand that I remain responsible for payment to the Provider for any services rendered and/ or supplies provided.

I acknowledge and agree that the insurer/plan administrator is under no obligation to accept this Assignment, that any benefit payment made in accordance with this Assignment will discharge the insurer/plan administrator of its obligations with respect to that benefit payment, and that in the event the benefit payment is made to me, the insurer/plan administrator will also be discharged of its obligation with respect to that benefit payment.

I understand that this Assignment will apply to all eligible claims submitted electronically by the Provider and that I may revoke it at any time by providing written notice to the insurer/plan administrator.

If I am a spouse or dependent, I confirm that I am authorized by the plan member to execute an assignment of benefit payments to the Provider.

____
Date

____
Signature

____
Print Name

Credit Card Information

We now require a credit card on file for all clients at Coastal Sports and Wellness Inc. with insurance companies that require a paper claim to be submitted for reimbursement.
For a full list of insurance companies this includes, see the front desk.

All clients will be notified via email or phone in the event that your card is being charged.

Name on Card ____

Credit Card Number ____

Expiration Date ________ /_________ CVV Code _________________
Month Year (3 digits on back of card)

Informed Consent

I, _______________________________(client), acknowledge that I am willingly providing my correct credit card information to Coastal Sports and Wellness Inc., for use only in cases where:

a) Online direct billing submission covers less than anticipated amount and other payment type is not arranged within one week of being notified by clinic of insurance issue(s).
b) Payment is not provided upon leaving the clinic
c) 24 hour cancellation policy not met (Full price of service will be charged)

I understand that I will be required to provide this information in order to continue treatments at Coastal Sports and Wellness Inc., and that this form is to be updated annually.

I understand that Coastal Sports and Wellness Inc. will only use my credit card information for reasons stated above with proper notification (via email or phone) prior to use by clinic.

Signature: ___________________________________ Date: __________________
(if child under 18, legal guardian must sign)