REGISTRATION FORM

NAME: _____
Last First Middle Initial

ADDRESS: _____ APT #: _____

□ Brantford, ON □ Hamilton, ON □ Paris, ON □ Other: _____

Postal Code: _____ Home: (____) _____

Occupation: _____ Work : (____) _____

Cell : (____) _____

BIRTHDATE: _____ SEX: M F WEIGHT: HEIGHT:
Day Month Year

Email address: _____

HOW DID YOU HEAR ABOUT DR. LIN?:

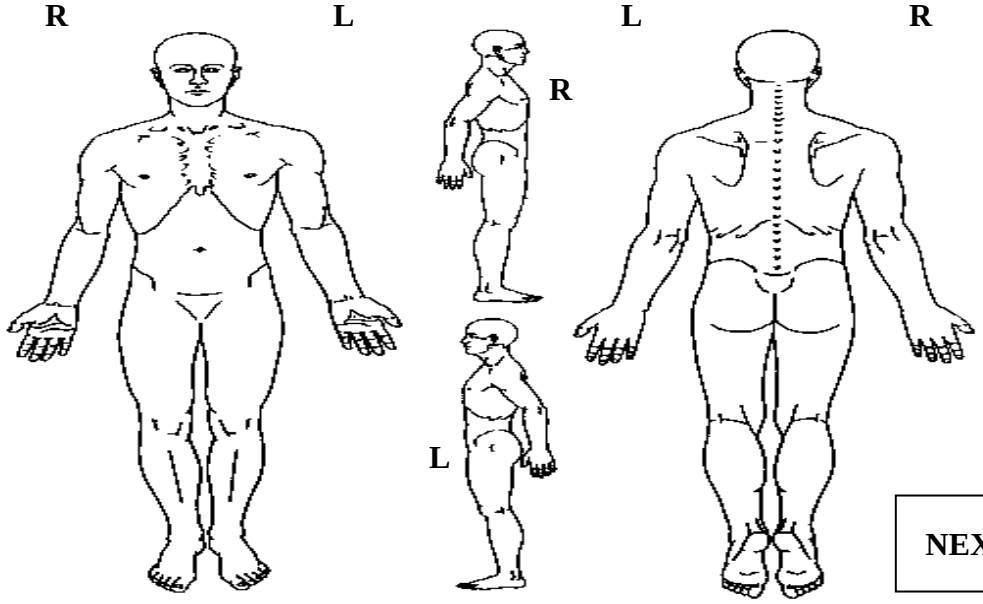
□ Referred by Family Physician □ Referred by Prior Clients □ Yellow Pages
□ Passed by Clinic while in St. Joseph's Lifecare Centre □ Newspaper Article
□ Other: _____

REASON FOR SEEING US TODAY?: _____

PRIOR TREATMENT(S) THIS CONDITION(S): □ None _____

USING THE FOLLOWING SYMBOLS, PLEASE INDICATE ON THE DIAGRAM BELOW:

X- PAIN O- UNUSUAL SENSATION S- STIFFNESS



NEXT PLEASE ⇒

PRIOR SURGERY(S) & CURRENT MEDICATION(S): □ None _____

_____

_____

FAMILY PHYSICIAN: _____ **TEL:** (____)_____

PLEASE CIRCLE THE NUMBER THAT BEST APPLIES TO THE LEVEL OF PAIN THAT YOUR CONDITION CAUSES:

No Pain		Slight Pain			Moderate Pain			Severe Pain		Unbearable Pain
0	1	2	3	4	5	6	7	8	9	10

PLEASE INDICATE ALL OTHER CONDITION(S) OR ADDITIONAL CONCERN(S) BELOW WHICH APPLY TO YOU:

□ asthma/allergies
□ headaches
□ gallbladder
□ arthritis
□ seizures/epilepsy
□ liver disease
□ high blood pressure
□ stroke
□ kidney
□ high cholesterol
□ thyroid disorder
□ heart disease
□ diabetes
□ tuberculosis
□ cancer
Other_____
□ chronic lung disease
□ ulcers
□ bleeding/clotting disorder
□ mental illness
□ pregnant
□ osteoporosis

PLEASE INDICATE ANY CONDITION(S) LISTED ABOVE WHICH APPLY TO MEMBERS OF YOUR FAMILY AND NOTE RELATIONSHIP (I.E. MOTHER , FATHER, GRANDPARENTS, ETC.):

_____

YOUR TREATMENT GOALS (PLEASE SELECT ONE):

□ I am interested in help with my current condition(s) only.
□ I am interested in help with my current condition(s), as well as in learning how to correct and prevent it in the future.

_____ _____
Signature Date

Email Contact Consent: We use an online program to provide your individualized exercises and stretches. This program provides in depth video demonstration of each exercise as well as a description. Do you consent to allowing your therapist to contact you via email for exercise prescription purposes? □ Yes □ No

Alternate preferred email: _____

PRIVACY POLICY

We will not use such information without your consent, or pass or sell such information to other parties not involved in assisting us to provide our services to you.

We will use your personal information for the following purposes:

1. To communicate with other Health Care Providers and Medical Suppliers, relevant to your health condition, including those that have referred you to us.
2. To communicate with third party(s) responsible for the finance and/or enrollment of your treatment, including WSIB and your private insurance company as required by law.
3. To process and invoice payments, including Unpaid Accounts.
4. For Teaching and demonstrating purposes on an Anonymous Basis.
5. To contact you to insure proper continuation of care.
6. To comply generally with the Law.

Access to such information within this office is restricted to office employees who have been advised to keep such information confidential and we have physical and system safeguards in place to prevent unauthorized access.

Should you wish to access your Personal Information or to withdraw your consent for our storage and use of your Personal Information, you may do so at any time in writing.

CONSENT TO EXAMINE

I give full consent to Dr. Gene Lin B.Sc., D.C. to perform a diagnostic examination in order to determine health status of musculoskeletal and nervous system. With this consent I understand the assessment may include stressing the body to recreate and reproduce symptoms of pain in order to determine the correct diagnosis and treatment. Some forms of diagnostic examination will include regional examinations based on complaints to assess neurologic and musculoskeletal compromise, postural assessments, orthopedic tests, neurologic tests, palpation assessments. Each examination will be based upon complaints and health history of the patient. Each patient will be re-examined as determined by Dr. Gene Lin to track progress.

Printed Name of Patient: _____

Signature of Patient or Parent/ Guardian (if under 18): _____

Today's Date: _____

Witness Name: _____

Witness Signature: _____

CURRENT FEE SCHEDULE

Fee Schedule:

Chiropractic Initial Visits:		**Orthotics:**	
Comprehensive Examination	$100	Custom Orthotics	$450
Primary Examination	$70	Orthotic Shoes (w/ orthotic)	$50

Manual Soft-tissue Therapy

	15 minutes	40 minutes	60 minutes
Chiropractic	$40	$70	$85

	15 minutes	30 minutes	40 minutes
Massage Therapy	$45	$55	$70

60 minutes
$95

Other Services:

Shockwave Therapy Only	$70 - $95
Shockwave & Manual Therapy	$90 - $115
Chiropractic Adjustments	$30
Acupuncture/Modalities	$40

MISSED APPOINTMENTS:

As a courtesy to our patients, it is our policy that we be notified a minimum of 24 hours in advance of a cancellation. There will be a missed appointment fee of $15.00 if we are not notified.

PAYMENT:

Payment is due at the time of the treatment, or monthly with a pre-authorized payment form.

I have read the above information and I understand that:

1. I am financially responsible for any fees or services not covered by insurance policy.
2. I am considered discharged for my condition of my own accord if multiple appointments are missed without cancellation notification to this office.
3. I am financially responsible for any administrative fees and/or "NSF" fees in the event of cancelled or bounced cheques.
4. There is a "no refund/ credit only" policy applied to all areas of treatment.

Date: _____ Signature: _____

Guardian: _____

(If patient is under 18 year of age)