iWellness.ca
Rehab & Wellness Clinic

2221 Keele Street, Suite 302
Toronto, ON M6M 3Z5
Phone:416-759-8099
Fax:416-759-9085
www.iwellness.ca

CHIROPRACTIC FEE SCHEDULE

Regretfully, as of December 12, 2004, the Ontario Government has removed all OHIP coverage for chiropractic services. This service interruption is expected to continue until legislated otherwise.

However, please note that many third party insurance coverage plans (through the workplace) still cover for these services. Patients should understand that they are required to pay for all services rendered and reports provided.

Motor vehicle accident clients or WSIB patients will not be required to pay up front for services rendered but will be held responsible for these fees and interest should coverage for their conditions become unavailable.

The service fees for regular or non-MVA treatments are as follows:
(Other fees are listed on the clinic website)

Initial Visit $100.00

Re-Assessment $85.00

Follow - Up(30 Min) $50.00

Follow - Up(45 Min) $85.00

Follow - Up(60 Min) $100.00

All patients will receive a receipt at the end of the visit schedule for their records and/or submission to a third party insurance company. MVA or WSIB billing is done directly with the insurance company in question once approval is received and is based on the current practitioner rates regulated by Financial Services Commission of Ontario.

_____
Patient Name (Print)

Date:_____

_____
Patient Signature

Please note that 24-hour appointment cancellation notice is required to avoid charges.

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INFORMED CONSENT
FOR CHIROPRACTIC THERAPY

I **hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and, if necessary, diagnostic x-rays, on me by the Doctor of Chiropractic named below and/or anyone working in this clinic authorized by the Doctor of Chiropractic named below.**

I have had an opportunity to discuss with the Doctor of Chiropractic named below and /or with other office or clinic personnel, the nature and purpose of chiropractic, adjustments and other procedures. I understand that results are not guaranteed.

I further understand and am informed that, as in all health care, in the practice of chiropractic there are some very slight risks to treatment, including, but not limited to, muscle strains and sprains, disc injuries, and strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely on the doctor exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I have read the above consent. I have also had an opportunity to ask questions about content, and by signing below I agree to the above mentioned chiropractic procedure. I intend this consent form to cover the entire course of treatment for my present condition.

TO BE COMPLETED BY PATIENT:

_____
Print Patient's Name:

Date Signed: _____

_____
Signature of Patient

OFFICE USE ONLY

Name: _____

Date: _____

Signature: _____

Dr. J. Balkansky, B.Sc., D.C.

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INITIAL INTAKE FORM

PLEASE PRINT

Date: _____

Welcome to iWELLNESS CLINIC! In order to serve you better, please take a moment to complete this form. If you require assistance, please see the receptionist. When finished, kindly return this form to the front desk.

Have you ever been here before? ☐ Yes ☐ No If Yes, When? _____
How did you learn about us? (if referred, please name the referral) _____

Patient Information (please complete all the fields below**)**			
Last name	First Name		Intl.
Street Address			
City/Town	Province	Postal Code	
Date of Birth	Gender ☐ M ☐ F		Mobile Tel.
Name of Emergency Contact	Relationship		Emergency Contact
Name of Family Doctor	Family Doctor Tel.		Patient's Email

Case Information ***(please indicate the reason for your visit and complete all the related information)***

☐ **Automobile Accident** **Date of Accident** _____ **Name of Automobile Insurance Company** _____

Have you already reported your injuries to the insurance company? ☐ Yes ☐ No
Were you employed at the time of the accident? ☐ Yes ☐ No
Do you have a legal representative? ☐ Yes ☐ No
(please provide the name)_____
Do you have Extended Health Care benefits Coverage? ☐ Yes ☐ No
(please provide name of insurer)_____

☐ **Work Injury** **Date of Accident** _____ **Claim Number (if Known)** _____

Nurse Case Manager: Tel.

WSIB Adjudicator: Tel.

☐ **Other** _____

Patient Signature (please print your name, sign, and date)		
To the best of my knowledge, I certify that the information provide above is true and correct.		
Name of Patient	Signature of Patient	Date

Please present the following documents:

☐ Driver's License ☐ Police Report ☐ Insurance Pink Slip
☐ Extended Health Benefit Card ☐ Other _____

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PLEASE PRINT

PATIENT'S NAME:

Please mark with an X if any of the conditions exist:

- ☐ Allergies
- ☐ Aneurysm
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fatigue
- ☐ Heart conditions
- ☐ Hepatitis
- ☐ HIV
- ☐ Nerves
- ☐ Osteoporosis
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Polio
- ☐ Psoriasis
- ☐ Respiratory Conditions
- ☐ Sinus Conditions
- ☐ Sleeping Difficulty
- ☐ Strokes
- ☐ V.D.

Please mark with an X if you had any of the below childhood conditions:

- ☐ Chicken Pox
- ☐ Chronic Ill
- ☐ Diphtheria
- ☐ Ear infections
- ☐ Measles
- ☐ Mumps
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Tubes in Ears
- ☐ Typhoid Fever
- ☐ Whooping Cough

Please indicate any other conditions the Doctor of Chiropractic should be made aware of:

_____

_____

_____

_____

_____

_____

OFFICE USE ONLY

Name: _____

Signature: _____ **Date:** _____
Dr. J. Balkansky, B.Sc., D.C.

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