SUTHERLAND-CHAN® CLINIC
creating healthier lifestyles

PRIVACY POLICY

Your knowledge and consent are required before we may collect, use, or disclose your personal information except in rare circumstances (i.e. subpoena, medical emergency, and debt collection). If you have any questions about this policy, please ask our receptionist.

Sutherland-Chan Clinic's client Privacy Policy is posted at the clinic, copies are available at reception, and it can be viewed online at www.sc-clinic.com under the menu 'Policies – Client Policies'.

Email Notification

I understand that only if I check off the following box(es) will I receive an email from Sutherland-Chan Clinic and that I have an option to be taken off the email list at any time by sending an email to mail@sc-clinic.com.

EMAIL

- ☐ Confirmation of appointment
- ☐ Email reminder to book an appointment **(monthly basis)**
- ☐ Email contact **(Re: cancellations, appointments, availabilities, etc.)**
- ☐ Advertising, promotions, and research **(e.g. sidewalk sales, draws for gift certificates, massage event, and opportunities to participate in research)**

Email: ____

GENERAL POLICIES

Massage Treatment

Your massage treatment includes assessment, reviewing the health history form with your therapist, massage, and self-care advice at the end of the treatment.

First Visit

Your Registered Massage Therapist (RMT) will review your health history form with you and will ask you questions to ensure that you receive a treatment that meets your needs. You will be asked to update this form yearly for address changes and any health-related changes that your RMT should be aware of. If you are a client at more than one Sutherland-Chan Clinic, you are required to fill out a heath history form at each clinic you attend.

Illness

If you have a fever or a cough related to flu or cold symptoms, please call and reschedule your appointment. Massage is contraindicated for fevers and can exacerbate flu-like symptoms. Please leave a message for your therapist if you need advice.

Soft Scent Policy

Please refrain from using perfumes and other scented products prior to your treatment.

Please Initial: ____________

Cell Phones

We ask that you do not make or receive phone calls on portable devices while in the clinic.

LATENESS POLICY

Clients are responsible for the time they reserve for their appointment. If you are late for your appointment the treatment will still end at the designated time with no change in fee.

CANCELLATION POLICY

When you book an appointment with an RMT, you are booking that RMT's time. In order to accommodate all our clientele we need 24 hours' notice of cancellation and/or rescheduling; less than that is inadequate time for us to offer your appointment time to others. If you are unable to make your appointment, we request that you call 24 hours in advance. If you do not call to cancel and/or reschedule before the 24-hour period, a cancellation fee will be charged.

Cancellation fees are ~55% of treatment fees, subject to HST, and subject to change with notice. The full cancellation fee is given to the RMT. Please note that your RMT only receives payment if you pay the cancellation fee. For more information, please ask reception.

*****If you book within the 24-hour time frame, the policy is in effect immediately.*****

I have read, understood, and agree to both pages one and two of this policies document, including:

- ***Privacy Policy*** **– I consent to the collection, use, and disclosure of my information as described in Sutherland-Chan's client Privacy Policy.**
- ***Cancellation Policy*** **– I agree to pay the cancellation fee if I cancel or reschedule within the 24 hours preceding my appointment time.**
- ***Lateness Policy*** **– I agree to pay for the full time I reserved with the therapist even if the treatment length is decreased because I arrived late for my appointment.**

Signature: ____________________________ **Date: ____________________________**

Thank you for your consideration and cooperation.

If you have any questions about Sutherland-Chan policies, please do not hesitate to ask our receptionist. If you have any questions about massage therapy, your RMT be pleased to answer them. Massage treatments by a RMT may be covered under your insurance plan; ask your plan coordinator if you are eligible for reimbursement.

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HISTORY FORM

An accurate health history is important to ensure that it is safe for you to receive massage treatment. All information gathered for this treatment is confidential except as required or allowed by law. Written authorization will be required for release of any information.

A 24-hour cancellation notice is required otherwise a missed appointment fee will be charged. This form must be updated annually.

Given Name: ____

Address: ____

City: _______________ **Prov.** ______ **Post. Code:** ___________

Tel. Home: ____

Tel. Bus.: ____

Tel. Cell: ____

Email: ____

Preferred contact: ☐ **Tel. Home** ☐ **Tel. Bus.** ☐ **Tel. Cell** ☐ **Email**

Preferred Name: ____

Family Name: ____

(To appear on receipt)

D.O.B.: MM / DD / YYYY **Gender:** ____________________

Occupation: ____

Do you have a Family Doctor? ☐ **Yes** ☐ **No**

Doctor/Clinic Name: ______________________________

Address: ______________________________

Tel: ____________________ **Fax:** ________________

Emergency Contact: ______________________________

Tel: ____________________ **Relationship:** ________________

How did you hear about our Sutherland-Chan Clinic?

☐ **Friend** ☐ **Coworker:** ______________________________

☐ **Other Sutherland-Chan locations:** ________________________

☐ **Healthcare Provider:** ______________________________

☐ **Other:** ____

Have you received massage therapy before? ☐ **Yes** ☐ **No**

Are you receiving treatment from other healthcare providers?

☐ **Chiropractic** ☐ **Physiotherapy** ☐ **Acupuncture** ☐ **Naturopathic** ☐ **Osteopathy** ☐ **Other:** ________________________

Address: ____ **Tel:** ____________________ **Fax:** ____________________

Why are you seeking massage therapy today? ____

____

Current Medications/Drugs	**Reasons/Indications for medication/drug**

Soft Tissue/Joints *(Please check and specify)*

***Side**: Left (L), Right (R);* **Symptoms:** *Pain (P), Stiffness (St), Numbness (N), Tingling (Ti), Twitching (Tw), Swollen (Sw), Other (O)*

	Present	**Past**
☐ neck	____________	____________
☐ shoulder	____________	____________
☐ upper back	____________	____________
☐ mid back	____________	____________
☐ low back	____________	____________
☐ chest	____________	____________
☐ arm/hand	____________	____________
☐ hips	____________	____________
☐ knees	____________	____________
☐ legs/feet	____________	____________

Other current symptoms: ______________________________

____

Accident/Injury

Car Accident ☐ **Work Related** ☐ **Other** ____________________

Date: MM / DD / YY

Physical Limitations: ______________________________________

____

Surgery

Type: ____

Date: MM / DD / YY

Type: ____

Date: MM / DD / YY

Type: ____

Date: MM / DD / YY

Do you have any pins / wires / prosthetics? ☐ **Yes** ☐ **No**

Specify:____

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HEALTH HISTORY **Please indicate ☑ conditions you are currently experiencing or have experienced in the past.**

Cardiovascular

- ☐ high blood pressure
- ☐ low blood pressure
- ☐ heart attack
  date: MM / DD / YY
- ☐ phlebitis / DVT
  date: MM / DD / YY
- ☐ stroke / CVA
  date: MM / DD / YY
- ☐ pulmonary emboli
- ☐ pacemaker / defibrillator
- ☐ heart disease
- ☐ angina
- ☐ chronic cong. heart failure
- ☐ swelling of ankles

Respiratory

- ☐ chronic cough
- ☐ shortness of breath
- ☐ bronchitis
- ☐ asthma
- ☐ emphysema
- ☐ pneumonia
- ☐ sinus problems

Gastroinstestinal

- ☐ irritable bowel syndrome
- ☐ colitis
- ☐ gastroenteritis
- ☐ Crohn's disease
- ☐ constipation

Reproductive Health

- ☐ pregnant
  due date: MM / DD / YY
- ☐ gynecological conditions:
  ____
- ☐ breast pain
- ☐ cysts
- ☐ breast lift, augmenta'n, or reduc'n
  date: MM / DD / YY
- ☐ menopause
- ☐ hysterectomy
  date: MM / DD / YY

Mental Health

(if comfortable sharing)

- ☐ depression
- ☐ anxiety/PTSD
- ☐ other: ___________________

Face, Head & Neck

- ☐ tooth/jaw/ear pain or TMJ
- ☐ headaches
  type: ___________________
- ☐ head trauma
  date: MM / DD / YY
- ☐ vision loss
- ☐ hearing loss

Infectious Disease

- ☐ hepatitis
- ☐ infectious skin conditions
- ☐ herpes
- ☐ tuberculosis
- ☐ HIV
- ☐ other infection:
  ____

Skin

- ☐ skin condition
  type: ___________________
- ☐ bruise easily
- ☐ varicose veins
- ☐ athlete's foot
- ☐ loss of sensation
- ☐ skin irritations

Other Conditions

- ☐ positional vertigo
- ☐ neurological conditions:
  ____
- ☐ epilepsy
- ☐ diabetes
  type: __________________
  pump: ______________
- ☐ allergies: _________________
  ____
- ☐ anaphylaxis: _______________
  ____
- ☐ medical alert bracelet
  condition/allergy:
  ____
- ☐ cancer: ___________________
  ____
- ☐ arthritis
  type: ___________________
  location(s): _______________
- ☐ haemophilia
- ☐ kidney/bladder problems
  type: __________________
- ☐ osteoporosis/osteopenia
- ☐ smoker

Overall, how is your general health: ____

Is there family history of any of the above conditions, health concerns, allergies, or sensitivities (if yes, which?):

____

____

Any other conditions, health concerns, surgeries (old), accidents (old), or injuries (old) not otherwise listed? Please describe:

____

____

I have read the above information and have stated all my previous and current medical conditions. I take it upon myself to update the massage therapist regarding any changes in my condition. I understand that all massage treatments will be discussed and planned with the massage therapist and will require my informed consent. I understand the 24-hour cancellation policy and agree to pay the missed appointment fee if I cancel within 24 hours preceding my appointment time.

I understand Sutherland-Chan's lateness policy that I am responsible to pay for the time I reserved with the therapist, regardless of the time I arrive and I am ready for my appointment.

Client Signature: ____________________________________ **Date:** ______________________

UPDATED ***(To be revised annually)***

Client Signature: ____________________________________ **Date:** ______________________

Client Signature: ____________________________________ **Date:** ______________________

Client Signature: ____________________________________ **Date:** ______________________

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RELEASE OF INFORMATION TO INSURANCE COMPANIES

Due to online submitting of insurance claims, insurance companies are randomly selecting clients and calling the clinics they attend to verify appointment dates and amounts. As a client of this practice, we are concerned that delays in confirming this information will result in a delay of you receiving your reimbursement cheque. Complete and sign the applicable portion of the form below for us to confirm **only** your dates and amounts with the insurance companies requesting this information. No other information will be released unless we receive an additional signed consent or are required to by law. This signed release form will remain with your file.

Client Information:

Last Name	First Name	Initials

Address

Telephone Number	Date of Birth

Substitute Decision Maker:
Please include copies of documents to substantiate authority as a substitute decision maker.

Last Name	First Name	Initials

Address

Telephone Number	Relationship to the client

I ____, hereby authorize Sutherland-Chan to release only the date(s) and amount(s) of my treatment(s) in response to insurance companies' inquiries regarding my attendance at Sutherland-Chan Clinic Inc.

Signature of Client/
Substitute Decision Maker: ____ Date: ____________________

UPDATED ***(Permission granted from newest date signed)***

Client Signature: ____ **Date:** ____________________

Client Signature: ____ **Date:** ____________________

Client Signature: ____ **Date:** ____________________

Internal Use Only

Agent: ____________________ Ins. Co: ____________________ Date of Inquiry: ____________

Agent: ____________________ Ins. Co: ____________________ Date of Inquiry: ____________

Agent: ____________________ Ins. Co: ____________________ Date of Inquiry: ____________

Agent: ____________________ Ins. Co: ____________________ Date of Inquiry: ____________

Agent: ____________________ Ins. Co: ____________________ Date of Inquiry: ____________

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