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 a question on any of this, please ask our receptionist.

Sutherland-Chan'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; 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 should I choose not to receive future emails from Sutherland-Chan.

☐ Confirmation of appointment

☐ Email reminder to book an appointment **(monthly basis)**

☐ Email Contact **(Re: cancellations, appointment availabilities, etc.)**

☐ Advertising, Promotions, & Research **(E.g. sidewalk sale or booths with free in-chair massage, handouts or draws for massage gift certificates, massage presentations, & opportunities to participate in research)**

Email: ______________________________

GENERAL POLICIES

Massage Treatment Entails

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

First Visit

Your 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 Registered Massage Therapist (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 large amounts of perfumes and other scented products.

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

Sutherland-Chan has a cancellation policy, when you book an appointment with a therapist you are booking that therapist'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 it 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. 100% of the cancellation fee is given to the massage therapist. Please note that your massage therapist only receives payment if you pay for 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 agreed to both pages one and two of this policies document. Including:

- ***Privacy Policy*** **– I consent to the collection, use, or 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 Registered Massage Therapist will be pleased to answer them. Massage treatments by a Registered Massage Therapist may be covered under your insurance plan, ask your plan coordinator if you are eligible for reimbursement.

SUTHERLAND-CHAN® CLINIC
massage therapy

HISTORY FORM

An accurate health history is important to ensure that it is safe for you to receive a 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: ______________________________ **Family Name:** ______________________________

(To appear on receipt)

Address: ______________________________

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

City: ____________ **Prov.** ______ **Post. Code:** __________

Occupation: ______________________________

Tel. Home: ______________________________

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

Doctor/Clinic Name: ______________________________

Address: ______________________________

Tel.: ____________________ **Fax:** ____________________

Tel. Bus.: ______________________________

Tel. Cell: ______________________________

Email: ______________________________

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

Emergency Contact: ______________________________

Tel: ____________________ **Relation:** ____________________

Preferred Name: ______________________________

How did you hear about our Sutherland-Chan Clinic?

☐ **Friend** ☐ **Co-worker:** ______________________________

☐ **Health Care Provider:** ______________________________

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

☐ **Other:** ______________________________

Have you received Massage Therapy before? ☐ **Yes** ☐ **No**

Are you receiving treatment from other Health Care 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:______________________________

SUTHERLAND-CHAN® CLINIC
massage therapy

HEALTH HISTORY **Please indicate ☑ conditions you are currently experiencing or have 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/augment./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
- ☐ athletes foot
- ☐ loss of sensation
- ☐ skin irritations

Other Conditions

- ☐ positional vertigo
- ☐ neurological conditions:
  - ________________________
- ☐ epilepsy
- ☐ diabetes
  - type: ________________
  - ins. pump: ______________
- ☐ allergies: ________________
  - ________________________
- ☐ anaphylaxis: ______________
  - ________________________
- ☐ medical alert bracelet
  - condition/allergy:
  - ________________________
- ☐ cancer: ________________
  - ________________________
- ☐ arthritis
  - type: ________________
  - location: ______________
- ☐ 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 (if yes, which?):

____

____

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 yearly)***

Client Signature: ______________________________ **Date:** ____________________

Client Signature: ______________________________ **Date:** ____________________

Client Signature: ______________________________ **Date:** ____________________

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RELEASE OF INFORMATION TO INSURANCE COMPANIES

Due to the online submitting of insurance claims, insurance companies are randomly selecting clients and calling the clinics they attend to verify appointment dates and amounts. Under privacy rules and regulations, Sutherland-Chan is not permitted to divulge any information without a release form completed and signed by our clients. 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. Please complete and sign the applicable portion of the form below for us to confirm “only” your dates and amounts to the insurance companies requesting this information. No other information will be released unless we receive a signed consent form requesting additional information. 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 Contact Information:
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) to insurance companies’ inquiries regarding my attendance at Sutherland-Chan Clinic Inc.

Signature of Client/
Substitute Decision Maker: ____________________________________ 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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Agent: ____________________ Ins. Co: ___________________ Date of Inquiry: ____________

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Treatment Plan for: ________________________________ **Date**: ___________________ **Therapist**: ________________________

Appointment Time: _________ am/pm **Duration:** _____________ minutes **Fee:** $ _________ ☐ **CTT** ☐ **CTA**

Date of Injury/Accident: ___________________ **Current Medications/Therapies**: ____

Subjective: ☐Relax ☐Tx ☐Maintenance **Symptoms:** Location/Intensity/Frequency/ Onset /Duration/ Sight/Spread

____

____

____

____

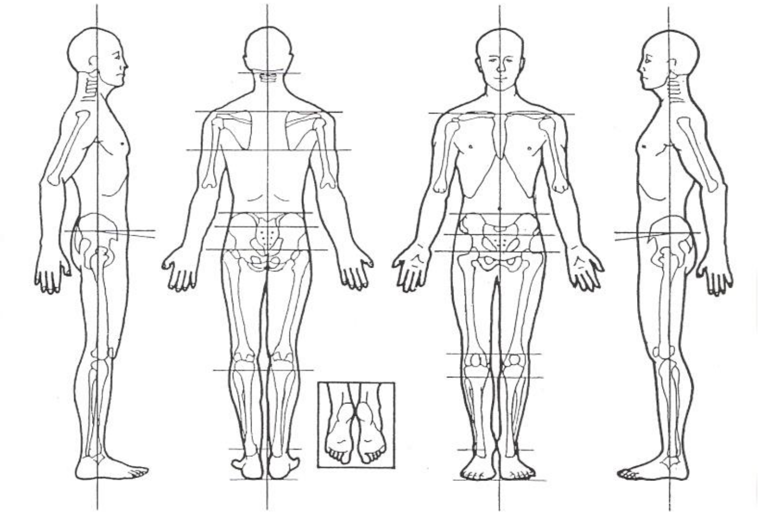
____

Limitations (Relieving) Daily Activities:____

____

____

Objective, Assessments & Results:



__Key__

Pain: O
Inflammation: ☆
Elevation: /
Adhesion: #
TeP: o

Muscle Tightness: ≡
Rotation: ↻
Scar, Bruises, Wounds: +++
Parasthesia: ∧∧
TrP: x

Client's Goal: **Treatment Goal (type/focus):**

Treatment Plan Discussed with Client: Yes / No **Received Informed Consent For Treatment Plan: Yes / No**

Areas Treated: ☐back ☐neck ☐shoulder ☐chest ☐head ☐face ☐arms L/R ☐hands ☐legs L/R ☐hip area ☐feet ☐abs ☐breast ☐FB

Techniques Used: light/mod/deep P ☐Swedish ☐MFR ☐TrP ☐joint mob ☐hydro ☐GTO ☐M stripping ☐rhythmic ☐CST ☐LD ☐frictions ☐breast massage ☐intra oral ☐stretch:____

____

____

Client Feedback: ↓ ↑ % of Δ ____ ☐looser ☐more relaxed ☐light headed ☐compliant to Remex________________________

____

____

Frequency/Duration/Self Care: Txs: ____ xs per week/biweekly/month for ____ mins for ____ weeks/month/ongoing ☐PRN

☐ESB ☐Hot shower ☐RICE ☐Postural Techniques ☐Breathing Techniques ☐Stretches/Strengthening: ______________________

____

Referral: ☐MD ☐DC ☐DOMP ☐PT ☐DAC ☐CST ☐RMT ☐ND ☐OTHER: ______________________________________

Anticipated Progression of Responses: **Reassessment schedule:** **Contraindications/Risks:**

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ONGOING CLINICAL RECORD

CLIENT'S NAME: ______________________________

Date: _________________ **Therapist**: ____ **CTT** ☐ **CTA** ☐

Appointment Time: __________ am / pm **Duration**: _________ minutes **Fee**: $______________

Subjective: Relax ☐ Tx ☐ Maintenance ☐

Assessment/Clinical Findings:

Areas Treated: ☐ back ☐ neck ☐ shoulder ☐ chest ☐ head ☐ face ☐ arms L R ☐ hands ☐ legs L R ☐ hip area ☐ feet ☐ abs ☐ breast ☐ FB

Techniques Used: light/mod/deep P ☐ Swedish ☐ MFR ☐ TrP ☐ joint mob ☐ hydro ☐ GTO ☐ M stripping ☐ rhythmic ☐ CST ☐ LD ☐ frictions ☐ breast massage ☐ intra oral ☐ stretch:______________________

Reassessment/Client Feedback: ↓ ↑ % of Δ ____ ☐ looser ☐ more relaxed ☐ light headed ☐ compliant to Remex

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Treatment Plan/Self Care: Txs: ____ xs per week/biweekly/month for ____ mins for ____ weeks/month/ongoing ☐ PRN

☐ ESB ☐ Hot shower ☐ RICE ☐ Postural Techniques ☐ Breathing Techniques ☐ Stretches/Strengthening: ___________________________

Referral: ☐ MD ☐ DC ☐ DOMP ☐ PT ☐ DAC ☐ CST ☐ RMT ☐ ND

Date: _________________ **Therapist**: ____ **CTT** ☐ **CTA** ☐

Appointment Time: __________ am / pm **Duration**: _________ minutes **Fee**: $______________

Subjective: Relax ☐ Tx ☐ Maintenance ☐

Assessment/Clinical Findings:

Areas Treated: ☐ back ☐ neck ☐ shoulder ☐ chest ☐ head ☐ face ☐ arms L R ☐ hands ☐ legs L R ☐ hip area ☐ feet ☐ abs ☐ breast ☐ FB

Techniques Used: light/mod/deep P ☐ Swedish ☐ MFR ☐ TrP ☐ joint mob ☐ hydro ☐ GTO ☐ M stripping ☐ rhythmic ☐ CST ☐ LD ☐ frictions ☐ breast massage ☐ intra oral ☐ stretch:______________________

Reassessment/Client Feedback: ↓ ↑ % of Δ ____ ☐ looser ☐ more relaxed ☐ light headed ☐ compliant to Remex

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Treatment Plan/Self Care: Txs: ____ xs per week/biweekly/month for ____ mins for ____ weeks/month/ongoing ☐ PRN

☐ ESB ☐ Hot shower ☐ RICE ☐ Postural Techniques ☐ Breathing Techniques ☐ Stretches/Strengthening: ___________________________

Referral: ☐ MD ☐ DC ☐ DOMP ☐ PT ☐ DAC ☐ CST ☐ RMT ☐ ND