Benefit Assignment Form

Instructions: This form must be filled out when claim payment is assigned to the Provider. Please retain this form in the patient's file for verification purposes for two years following closure of the patient file.

Provider: Stephanie Williams, RMT
Address: 86 Stanley Street
City/Province: Ayr, ON
Postal Code: N0B 1E0
Phone Number: (519) 394-0099

Patient: _____
Address: _____
City/Province: _____
Postal Code: _____
Phone Number: _____
Plan Number: _____
Certificate / Plan member Number: _____

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:

Electronic Transmission Authorization and Consent Form

Instructions: 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 closure of the patient file.

Provider: Stephanie Williams, RMT
Address: 86 Stanley Street
City/Province: Ayr, ON
Postal Code: N0B 1E0
Phone Number: (519) 394-0099

Patient: _____
Address: _____
City/Province: _____
Postal Code: _____
Phone Number: _____
Plan Number: _____
Certificate / Plan member Number: _____

Consent to Collect and Exchange Personal Information

Message to the Plan member, Spouse and/or Dependent regarding Personal Information

Personal information that we collect and disclose about you, and if applicable, your spouse and/or dependents, is used by the insurer and/or plan administrator and their 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.

Electronic Transmission Authorization and Consent Form

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.

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.

_____ _____

Date: Signature

Print Name:

Health History and Entrance Form

A complete health history helps us ensure it is safe to provide you with a massage treatment; please let us know if your status changes so we can update your form. All information given to us is confidential.

Name:_____ Email:_____

Your email address will never be shared with a third party

Home Phone:_____ Cell Phone:_____

Street:_____ Unit:_____ City:_____ Postal Code:__

Date of Birth (MM-DD-YY):_____ Occupation:_____

Do you have insurance benefits for massage? Yes No If yes, were you referred by your doctor? Yes No

Doctor's Address: Street:_____City:_____

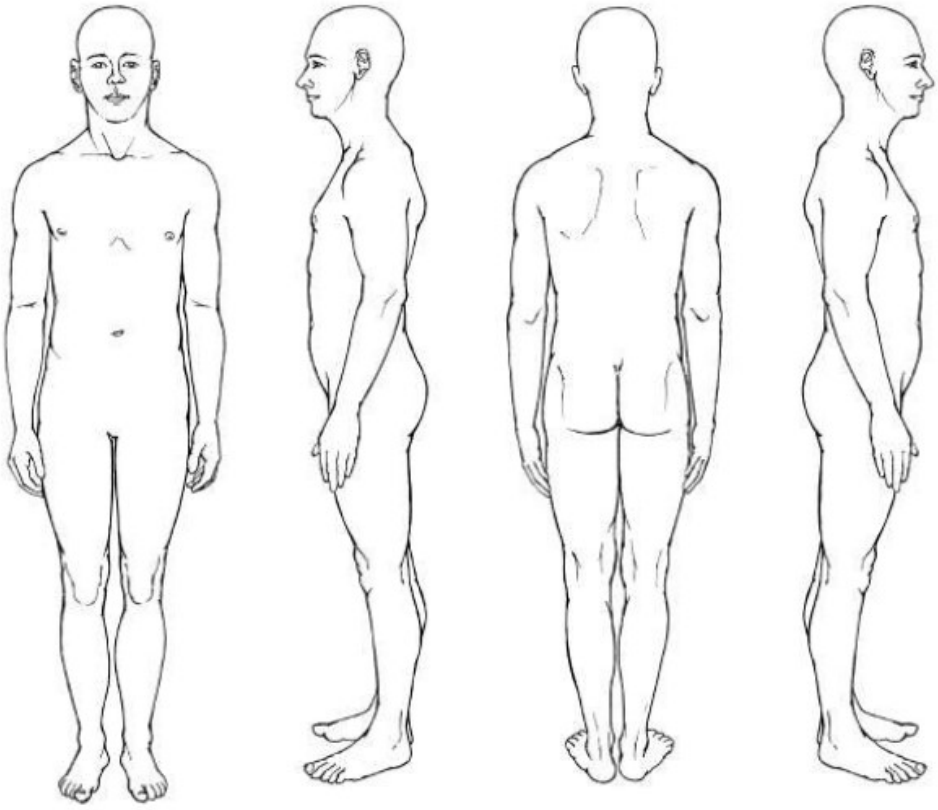
Have you had a professional massage before? Yes No

Do you see other healthcare practitioners? Chiro Physio Naturopath Osteopath

Other:_____

How is your overall health?_____

Please indicate areas you would like us to focus on and your primary area of complaint.



What is your primary complaint?

Please Check All That Apply

General Symptoms:
- ☐ Fainting / Dizziness
- ☐ Difficulty Sleeping / Fatigue
- ☐ Headaches / Migraines
- ☐ Numbness / Tingling;
  Where:_____
- ☐ Paralysis

Skin:
- ☐ Rashes
- ☐ Psoriasis
- ☐ Eczema
- ☐ Bruise Easily

Infections:
- ☐ Hepatitis
- ☐ Tuberculosis
- ☐ HIV / AIDS
- ☐ Herpes
- ☐ Athlete's Foot
- ☐ Warts

Respiratory:
- ☐ Chronic Cough
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema
- ☐ Family History of:_____

Joint/Muscular:
- ☐ Bursitis
- ☐ Arthritis
- ☐ Swelling
  Where_____
- ☐ Artificial Joints
  Where:_____
- ☐ Osteoporosis
- ☐ Fibromyalgia

Lifestyle (circle what best describes you)

Regular Exercise? Yes No Mostly
Drink Plenty of Water? Yes No Mostly

Do you Have/Have You Had:
- ☐ Diabetes
- ☐ Cancer
  Type:_____
  Onset:_____
  Current Stage:_
- ☐ Epilepsy
- ☐ Aneurysm/stoke
- ☐ Hypo/hyper glycaemia
- ☐ Depression
- ☐ MS
- ☐ Thyroid Problems
- ☐ Mental Illness

Cardiovascular:
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Heart Attack / Disease
- ☐ Congestive Heart Failure
- ☐ Heart Murmur
- ☐ Pacemaker
- ☐ High Cholesterol
- ☐ Varicose Veins / Phlebitis
- ☐ Family History of:_____

Gastrointestinal:
- ☐ Crohn's/Colitis
- ☐ Ulcers
- ☐ Gall Bladder Problems
- ☐ Liver Problems

EENT:
- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Hearing Difficulty
- ☐ Hearing Aid
- ☐ Allergies / Hypersensitivity
  To:_____
  Type of Reaction:_____

8 Hours of Sleep nightly? Yes No Mostly
Good Eating Habits? Yes No Mostly

Current Medications/Vitamins/Supplements:_____

Previous Major Illnesses/Operations/Accidents (include dates):_____

Family History of:_____

Other Serious Medical Conditions:_____

Please Read and Sign

I confirm the information on this form is correct to the best of my knowledge and will inform my therapist should anything change. I understand the therapist has the right to end any treatment due to inappropriate behaviour. I consent to the massage treatment plan set forth by my massage therapist. I recognize that a cancellation policy exists and it can be used at the discretion of the therapist.

Signature:_____ Date:_____