HYDROACTIVE
AQUATHERAPY & REHABILITATION
1 - 676 WESTBURNE DRIVE, CONCORD, ON, L4K 4V5
TEL: 905-879-1251 FAX: 905-884-2968
E-MAIL: INFO@HYDROACTIVE.CA

Check List

Client name: _____

- [ ] **Client ID**
- [ ] **Client Email**
- [ ] **Insurance info (Name, Policy #)**
- [ ] **EHC Info and Telus Consent Form**
- [ ] **Date of Loss**
- [ ] **Intake forms completed and signed**
- [ ] **Consent forms completed and signed**
- [ ] **Family doctor info (Name, Phone #)**
- [ ] **All information uploaded into Universal**
- [ ] **LR on file or OCF 1**

Notes: _____

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ATTENDANCE SHEET

Patient Name:_____

#	Date	COVID Screening/Temp. Check/No Symptoms	Patient's Signature
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
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21			
22			
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29			
30			
31			
32			

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PATIENT INFORMATION:

Last Name:_____ First Name:_____ Birth Date:_____

Address:_____

City:_____Postal Code:_____Email address:_____

Phone #: _____

MALE □ FEMALE □ # of children_____ Ages_____

Employer: _____ Occupation: _____

Did you stop working as a result of the accident: _____

Emergency Contact/Relation_____ Phone#: _____

INSURANCE INFORMATION: **MVA** □ **SLIP & FALL** □ **WSIB** □

Driver □ Passenger □ Pedestrian □ Bicycle □ Deemed At Fault: □ **NO** □ **YES**

Date of Accident: _____ Insurance Co Name: _____

Policy #:_____Policy Holder:_____ Claim #: _____

EHC INFORMATION

Do you have extended health insurance? □ Yes □ No

Insurance Company:_____ Group No: _____ Cert No:_____

Policy Holder:_____ DOB:_____

WSIB INFORMATION

Did your accident happen at work? □ Yes □ No

Claim No: _____ Adjudicator:_____ Nurse/Manager:_____

FAMILY PHYSICIAN:

Doctor Name: _____ Tel: _____ Fax: _____

LEGAL REPRESENTATIVE:

Company Name: _____Address: _____

Representative Name:_____ Tel: _____Fax: _____

PATIENT'S SIGNATURE: _____ DATE: _____

Payment Policy: Direct billing can be arranged with the provision that complete and accurate information is provided. If payment is made for services rendered by the clinic and the payment is issued to the patient/insured, please understand that it is your responsibility to reimburse the clinic accordingly.

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Patient Name:_____ **Date:**_____

MEDICAL HISTORY		
☐ Unexplained weight loss or gain	☐ Swollen ankles	☐ Arthritis (Osteo or Rheumatoid)
☐ Fatigue/loss of energy	☐ Calf pain- when walking	☐ Back pain- frequent / chronic
☐ Headaches	☐ Varicose veins/phlebitis	☐ Neck pain – frequent / chronic
☐ Migraines	☐ Recent Loss of Appetite	☐ Scoliosis
☐ Dizziness or Vertigo	☐ Difficulty swallowing	☐ Disc bulge/herniation
☐ Syncope (fainting)	☐ Indigestion or heartburn	☐ Disc degeneration
☐ Decreased hearing	☐ Nausea or Vomiting	☐ Joint injury
☐ Ringing in ears	☐ abdominal pain or ulcer	☐ Osteoporosis
☐ Failing vision	☐ Change in bowel habits	☐ Fybromyalgia
☐ Eye pain	_____ Diarrhea _____ Constipation	☐ Foot pain
☐ Double or blurred vision	☐ Digestive Problems	☐ Rashes or Hives
☐ Nose bleeds- frequent	☐ Kidney Problems	☐ Skin Problems:
☐ Sinus pain	☐ Liver Problems	☐ Sleeping- difficulty
☐ Teeth/Gum/Jaw pain- bleeding	☐ Gynecological problems	☐ Nervousness
☐ Hay fever/allergies	☐ Pregnant or could be pregnant	☐ Anxiety
☐ Shortness of breath	Due date:	☐ Depression
_____on exertion ____ lying flat	☐ Bruise easily	☐ Memory Problems
☐ Chest pain or tightness	☐ Cancer (type):	☐ Phobias:
☐ Chronic Cough	☐ Stroke :	☐ Moodiness
☐ Emphysema	☐ Heart Attack :	☐ Stress-excessive
☐ Bronchitis	☐ Pacemaker/other device:	☐ Mental illness
☐ Asthma	☐ Heart Disease	☐ Schizophrenia
☐ Diabetes	☐ Blood pressure (high / low)	☐ Other :
☐ Thyroid problems	☐ High cholesterol	
☐ HIV	☐ Convulsions/seizures	
☐ Infectious disease	☐ Tremor/hands shaking	
☐ Hepatitis (A, B or C)	☐ Muscle weakness	
☐ Blood disorders	☐ Numbness/tingling sensation	

HAVE YOU SUFFERED ANY OF THE FOLLOWING? PROVIDE DATE AND BRIEF DESCRIPTION		
☐ Falls:	☐ Head Injuries:	☐ Broken Bones:
☐ Dislocations:	☐ Work/sports injuries:	☐ Previous MVA:
☐ Surgeries/Hospitalization:	☐ Psychological treatment:	☐ Other:

CURRENT MEDICATIONS/SUPPLEMENTS LIST	
Name:	For what condition:
Name:	For what condition:
Name:	For what condition:
Name:	For what condition:
Medication allergies:	

Initial_____

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General Pain Disability Index Questionnaire	
NAME (Please Print):	**DATE:**

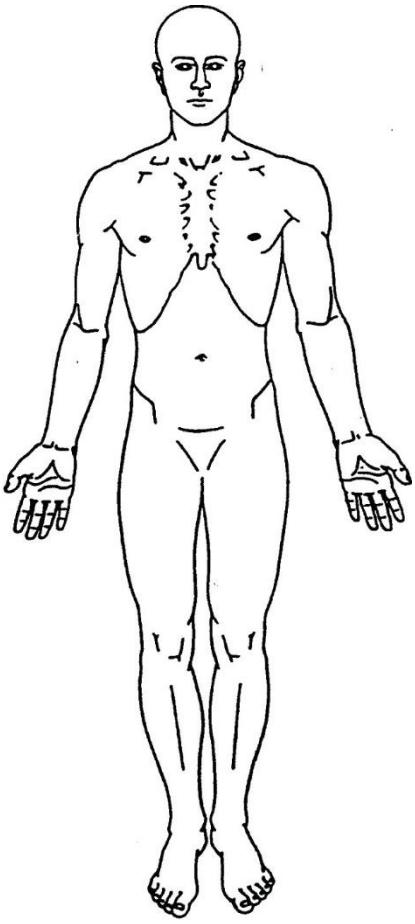
AREA OF COMPLAINT(S) AS FOLLOWS:

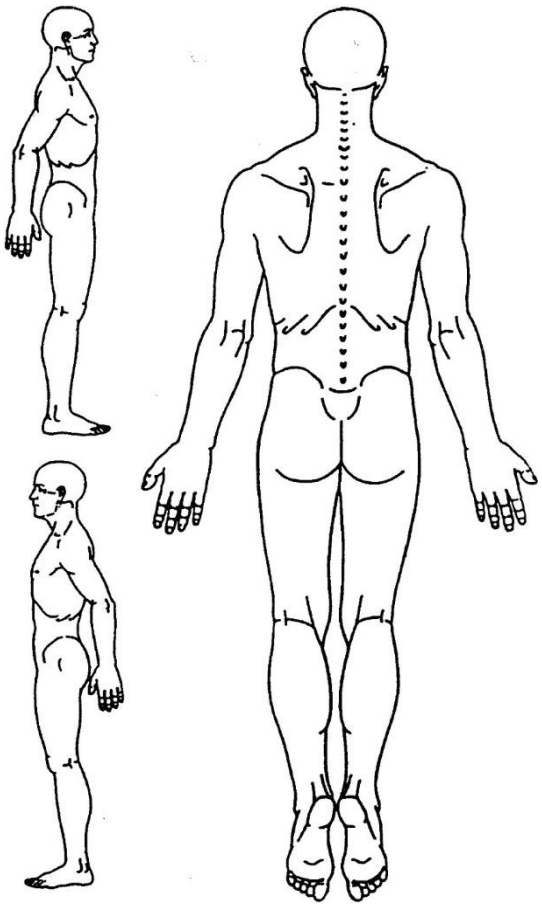
A= ACHE B =BURNING N =NUMBNESS P =PINS & NEEDLES S =STABBING O=OTHER

PLEASE RATE YOU PAIN ON A SCALE OF 1-10

1 BEING NO PAIN AND 10 BEING TOTALLY UNABLE TO FUNCTION

1___ 2___ 3___ 4___ 5___ 6___ 7___ 8___ 9___ 10___





Initial_____

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ACCIDENT PROFILE

Patient Name:_____ **Date:**_____

Were you working at the time of the accident? ☐ Yes ☐ No	Date of Accident:

Job Title		F/T P/T	Missed Time From Work? ☐Yes ☐No	Returned To Work? ☐Yes☐ No	
Student		F/T P/T	Missed Time From School? ☐Yes ☐No	Returned To School? ☐Yes ☐No	

Location of Accident:		Were you deemed at fault for the accident ☐Yes ☐No	
☐ Driver ☐ Front Passenger ☐ Rear Passenger ☐ Pedestrian ☐ Bicycle Number of Passengers:			
How did the accident happen?			
Were you wearing your seatbelt?	☐ Yes ☐ No	Did the airbags deploy?	☐ Yes ☐ No
Did you hit your head? If yes, where?			☐ Yes ☐ No
Did you hit any other part of your body inside the vehicle? If yes, where?			☐ Yes ☐ No
Did you lose consciousness? If yes, how long?			☐ Yes ☐ No
Were you able to exit the vehicle independently? If no, how did you exit?			☐ Yes ☐ No
Were you bleeding?	☐ Yes ☐ No	Any nausea or vomiting after accident?	☐ Yes ☐ No
Did the police arrive?	☐ Yes ☐ No	Was an accident report filed?	☐ Yes ☐ No
Did the ambulance arrive?	☐ Yes ☐ No	If yes, were you transported to hospital?	☐ Yes ☐ No

TREATMENT RECEIVED (DID YOU VISIT THE FOLLOWING?)		
	HOSPITAL	FAMILY PHYSICIAN
Dates:		Date:
Names / Locations:		Name:
Procedures / Examinations:	☐ X-ray ☐ Exam ☐ CT/MRI ☐ Ultrasound Results: _____	☐X-ray ☐Exam ☐CT/MRI ☐ Ultrasound Results: _____
Findings:		
Prescribed medication:		
Have you received treatment at any other therapy clinic for this accident? ☐ Yes ☐ No		
Name: _____ Start Date: _____ End Date: _____		
Frequency: _____times / week Type of therapy: ☐ Chiropractic ☐ Physiotherapy ☐ Massage ☐ Exercises		
Translation needed: ☐ Yes ☐ No		
Comments:		

I hereby certify that I have read and understand the information recorded and verify that it is true and accurate.

Initial_____

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BY SIGNING THIS DOCUMENT, YOU WILL WAIVE CERTAIN LEGAL RIGHTS, INCLUDING THE RIGHT TO SUE OR CLAIM COMPENSATION FOLLOWING AN ACCIDENT

PLEASE READ CAREFULLY

TO: HYDROACTIVE AQUATHERAPY & REHABILITATION INC. and its directors, officers, employees, instructors, guides, agents, representatives, independent contractors, subcontractors, suppliers, hosts, volunteers, successors and assigns (all of whom are hereinafter referred to as the "**OPERATOR**")

Name	Last	First	Initial
Address	Street		
	City	Province	Postal Code
Date of Birth			

ASSUMPTION OF RISKS

I am aware that the participation in the activities conducted by the OPERATOR (the "Activity"), use of the Activity equipment (the "Equipment") and attendance at the facilities where the Activity takes place (the "Facilities") involves many risks, dangers and hazards including, but not limited to: mechanical failure of Equipment or Facilities; postural stress; insufficient physical condition, fitness, or abilities; negligence of you or other participants; other undefined harm which or damage which is not readily foreseeable and other presently unknown risks or dangers; and **NEGLIGENCE ON THE PART OF THE OPERATOR. I UNDERTAND THAT NEGLIGENCE INCLUDES FAILURE ON THE PART OF THE OPERATOR TO TAKE REASONABLE STEPS TO SAFEGUARD OR PROTECT ME FROM THE RISKS, DANGERS AND HAZARDS OF THE ACTIVITY.**

I AM AWARE OF THE RISKS, DANGERS AND HAZARDS ASSOCIATED WITH THE ACTIVITY, AND I FREELY ACCEPT AND FULLY ASSUME ALL SUCH RISKS, DANGERS AND HAZARDS, AND THE POSSIBILITY OF PERSONAL INJURY, DEATH, PROPERTY DAMAGE AND LOSS RESULTING THEREFROM.

RELEASE OF LIABILITY, WAIVER OF CLAIMS, INDEMNITY AND IMAGE RIGHTS ASSIGNMENT AGREEMENT

In consideration of the OPERATOR accepting my application for participation in the Activity, and permitting my use of the Equipment and the Facilities, I hereby agree as follows:

1. **TO WAIVE ANY AND ALL CLAIMS** that I may have in the future, against the **OPERATOR AND TO RELEASE THE OPERATOR** from any and all liability for any loss, damage, expense or injury including death that I or my next of kin may suffer, resulting from either my use of or my participation in the Activity, use of the Equipment, presence on the Facilities, or travel outside the Facilities, **DUE TO ANY CAUSE WHATSOEVER, INCLUDING USE OF THE IMAGES (AS HEREINAFTER DEFINED), NEGLIGENCE, BREACH OF CONTRACT, OR BREACH OF ANY STATUTORY OR OTHER DUTY OF CARE OWED UNDER ANY APPLICABLE OCCUPIERS' LIABILITY LEGISLATION ON THE PART OF THE OPERATOR. I UNDERSTAND THAT NEGLIGENCE INCLUDES FAILURE ON THE PART OF THE OPERATOR TO TAKE REASONABLE STEPS TO SAFEGUARD OR PROTECT ME FROM RISKS, DANGERS AND HAZARDS REFERRED TO ABOVE;**
2. **TO HOLD HARMLESS AND INDEMNIFY THE OPERATOR** from any and all liability for any damage to property of, or personal injury to, any person or entity resulting from my participation in the Activity, use of the Equipment, presence on the Facilities, or travel outside the Facilities;
3. To follow and obey the rules and regulations provided by OPERATOR at all times during my participation in the Activity.
4. The terms of this release of this Agreement relating to waiver and indemnity shall survive termination of this Agreement. This Agreement shall be binding upon my heirs, next of kin, executors, administrators, assigns and representatives in the event of my death or incapacity. Any litigation involving the parties to this Agreement shall be brought solely within the Province of Ontario and shall be within the exclusive jurisdiction of the Courts of the Province of Ontario and governed by the laws thereof; and in entering into this Agreement, **I AM NOT RELYING UPON ANY ORAL OR WRITTEN REPRESENTATIONS OR STATEMENTS MADE BY OPERATOR** with respect to the safety of the Activity other than what is set forth in this Agreement. Should any provision in this Agreement be deemed invalid or unenforceable by a court of competent jurisdiction, such provision will only be ineffective to the extent of that restriction and all remaining provisions or parts thereof shall remain in full force and effect.

I CONFIRM THAT I HAVE READ THIS AGREEMENT AND UNDERSTAND, AND AM AWARE THAT BY SIGNING THIS AGREEMENT I AM WAIVING CERTAIN LEGAL RIGHTS WHICH I OR MY HEIRS, NEXT OF KIN, EXECUTORS, ADMINSITRATORS, ASSIGNS AND REPRESENTATIVES MAY HAVE AGAINST THE OPERATOR. I REPRESENT THAT I AM AT LEAST 18 YEARS OF AGE. I FURTHER REPRESENT THAT THERE IS NO MEDICAL OR PHYSICAL REASON WHY PARTICIPATION BY MYSELF COULD BE POTENTIALLY HARMFUL IN ANY WAY.

Signed this _____ day of _____, 202_.

PRINTED NAME _____ **SIGNATURE** _____

WITNESS NAME _____ **WITNESS SIGNATURE** _____

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CONSENT

I AUTHORIZE **Hydroactive Aquatherapy & Rehabilitation Inc** and its associates by this form or photocopy thereof, to collect, use and disclose to professionals involved in my accident rehabilitation, legal representative and insurance company any information relating to my health condition and treatment/assessment received as a result of the motor vehicle accident. I also authorize **Hydroactive Aquatherapy & Rehabilitation Inc** and its associates to collect, use and disclose any information relating to pre-existing or subsequently occurring health conditions that may be a barrier to my recovery as the result of the motor vehicle accident.

This shall be your full, complete, sufficient and irrevocable authorization for so doing.

Patient's signature_____

(printed name) _____

Date: _____, 202_

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DIRECTION/CONSENT FORM

PATIENT NAME	
TREATING FACILITY	Hydroactive Aquatherapy and Rehabilitation
AUTO INSURANCE COMPANY	
CLAIM #	
EXTENDED HEALTH INSURANCE COMPANY	
POLICY / GROUP #	
ID / CERTIFICATE #	
DATE OF LOSS	

I, the undersigned, do hereby authorize **Hydroactive Aquatherapy and Rehabilitation** to act on my behalf and take all steps it deems reasonable and/or necessary to affect recovery and re-imbursement from my firm/insurer for any and all expenses arising on my behalf for medical rehabilitation provided by **Hydroactive Aquatherapy and Rehabilitation** as a result of injuries sustained in connection to the injury dated above. Such steps may include negotiation, mediation and/or arbitration proceedings.

I, hereby authorize the above mentioned insurance companies to make direct payment to **Hydroactive Aquatherapy and Rehabilitation** for the services provided.

I agree to fully co-operate with **Hydroactive Aquatherapy and Rehabilitation** in its efforts and will attend in person, if required to assist in the above efforts.

I, the undersigned, do hereby agree to forward any and all payments that I may receive from my Extended Healthcare Insurance and/or Automobile Insurance Company to **Hydroactive Aquatherapy and Rehabilitation for my treatment**.

I also understand that if I or my legal representative/lawyer should settle my claim on a Full and Final basis with the insurance company it is my responsibility to include the outstanding amounts for treatment at **Hydroactive Aquatherapy and Rehabilitation.**

I understand that failure to do so could result in me being responsible for the payment of my account and may include applicable interest.

I acknowledge that if transportation is required, the services are provided by a 3rd party company not affiliated with **Hydroactive Aquatherapy and Rehabilitation**. **Hydroactive Aquatherapy and Rehabilitation** assumes no liability for these services. If I choose to use these services, I will do so at my own risk.

I have inquired, understand, and agree to the fees being charged in relation to my treatment.

A copy of this authorization shall be valid as original.

Dated this _____ day of_____, 20____.

_____ _____
Patient Print Name Patient Signature

_____ _____
Witness Name Witness Signature

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CONSENT FOR RELEASE OF MEDICAL INFORMATION

I, _____ hereby consent to and authorize the release of my medical information to my rehabilitation clinic, Hydroactive Aquatherapy & Rehabilitation. Please fax my medical information to **905-884-2968**.

Medical Information Requested:

- X-ray Reports
- Ultrasound Reports
- MRI/CT scan Reports
- Other_____

_____
SIGNATURE

_____
DATE

_____
DATE OF BIRTH

_____
HEALTH CARD NUMBER

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RESCHEDULING POLICY

Due to the limits on scheduling capacity, when patients cancel or miss appointments without providing sufficient notice, they prevent other patients from being seen for necessary care.

Providing our patients with exceptional care is of upmost importance to us at **Hydroactive Aquatherapy & Rehabilitation**, with these new changes in place we hope to better accommodate our patients needs.

Should you need to reschedule your appointments, please contact our office at 416-897-9792 or 905-879-1251 no later than 48 HOURS prior to your scheduled appointment.

If sufficient notification is not provided, you will be charged THE TOTAL COST FOR THE SERVICE/SERVICES scheduled on that day. If transportation is being provided to you by our facility, THE FULL AMOUNT FOR THE TRANSPORTATION EXPENSE will be charged in addition to the amount being charged for the missed appointment/short notice cancellation.

We appreciate your anticipated understanding and cooperation concerning this matter. We are committed to offering you excellent service and care.

Dated at _____ (CITY), this _____ day of _____, 20___

Patient Name_____ Signature_____

Witness Name_____ Signature_____

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AVAILABILITY OF PATIENT

HydroActive Business Hours

Physical Therapy: Monday 9:00 am to 1:00 pm & 4pm to 9pm
Aqua Therapy: Monday 9:00 am to 1:00 pm & 8:00 pm to 9:00 pm

Physical Therapy: Tuesday 9:00 am to 12:00 pm
Aqua Therapy: Tuesday 9:00 am to 12:00 pm

Physical Therapy: Wednesday 9:00 am to 3:30 pm & 4pm to 9pm
Aqua Therapy: Wednesday 9:00 am to 3:30 pm & 8:00 pm to 9:00 pm

Physical Therapy: Thursday 6:00 pm to 9:00 pm
Aqua Therapy: Thursday 8:00 pm to 9:00 pm

Physical Therapy: Friday 9:00 am to 2:00 pm
Aqua Therapy: Friday 9:00 am to 2:00 pm

Physical Therapy: Saturday 3:00 pm to 5:30 pm
Aqua Therapy: Saturday 2:30 pm to 6:30 pm

Please Provide Your Availability Below

- ☐ **Monday (available times):**_____
- ☐ **Tuesday (available times):** _____
- ☐ **Wednesday (available times):** _____
- ☐ **Thursday (available times):** _____
- ☐ **Friday (available times):** _____
- ☐ **Saturday (available times):** _____

Comments:_____
_____
_____
_____
_____
_____

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Patient Name:_____ **Date:**_____