File #_____

MYO CENTRE INC.

Massage Therapy & TCM Acupuncture

MASSAGE THERAPY INTAKE FORM

Name……Date of Birth……

Address……City……Postal Code……..

Phone …… Email……

Family Doctor…… Occupation……

Medications……

Other treatments undergoing……

Please circle all conditions that apply to you

Headaches / Migraines	Chronic pain	Fatigue
Vision problems	Muscle or joint pain	Tension or stress / PTSD
Hearing problems	Muscle or bone injuries	Depression or Anxiety
Injuries to face or head	Numbness or tingling	Sleeping difficulties
Sinus problems	Sprains Strains	Allergies **LIST PLEASE** ……
Dental bridges/braces	Arthritis Tendonitis	Rash Athletes foot
Jaw pain TMJ	Cancer Tumors	Infectious disease
Asthma, lung condition	Spinal column disorder	Blood clots
Constipation Diarrhea	Diabetes	Varicose veins
Hernia	Pregnancy	High / low blood pressure
Birth Control IUD	Heart Circulation	Abdominal Pain

Other medical conditions not listed

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Have you received Massage Therapy before? YES / NO When? ……

Do you exercise? YES / NO Do you drink at least 3 glasses of water a day? YES / NO Is your diet balanced? YES / NO

What are your exercises or activities?……

Present concern you would like addressed **……**

Is this the result of an injury or accident? **……**

Please circle your level of pain today (mild) 1 2 3 4 5 6 7 8 9 10 (severe)

WELCOME TO MYO CENTRE INC. We appreciate you choosing us as part of your health maintenance. Should you have any questions or concerns regarding therapeutic treatment and maintenance, the Registered Massage Therapist / Osteopath will explain all procedures to you.

PERMISSION TO TOUCH FOR MASSAGE THERAPY Please be advised that our therapies often include the exposure and touching of the inner thigh, buttocks region, chest (including partial breast tissue), abdominal region, and inside of the mouth (with gloved hand, if TMJ work is required). **We never** expose or touch nipple area, genitalia, or anal area. We respect your decision to have massage therapy and/or acupuncture as part of your health maintenance program and strive to keep you safe and comfortable.

Please give a **24 hour notice for ALL CANCELLATIONS** so we can fill that empty spot. It is our Policy to **CHARGE 50%** of your booked treatment if you do not give us the fore mentioned notice.

We offer **EMAIL REMINDERS** only of your appointments direct to your PC or Smart Phone

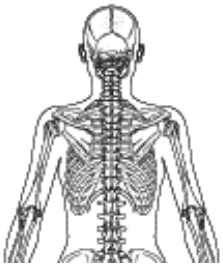
Please **CANCEL** appointments **ONLINE** **Call** 780 451-9290 or **Email** myoctr@telus.net

Permission to contact you? **Yes** ☐ **No** ☐

I, the undersigned, hereby certify that all the information on this form is complete and accurate. I agree to pay MYO CENTRE INC. all outstanding monies owing for massage treatments received at the above mentioned clinic, should my insurance company not pay within 90 days of the original invoice date. I give my permission to receive massage therapy. I have read the above information and agree to its conditions.

Signature……Date……

How did you hear about us? _____



FOR YOUR HEALTH SINCE 1995

C.Wyrozub, RMT, CEO

MYO CENTRE INC.
Massage Therapy & TCM Acupuncture

Direct Billing Set Up

Name……

Insurance Company…… MEDAVIE BLUE CROSS Only

Insurance Plan Number…… FOR DVA, CAF, RCMP ONLY (K, M, or R no.)

Insurance ID Number…… **……**

Policy Holder Name……

Date of Birth……..

Do you need a Doctor's Note? Yes ☐ **No** ☐

Maximum Benefit per Year……

Benefit %.....

We only direct bill primary insurance coverage. Secondary must be paid on the date of your appointment and we will issue you a receipt to submit to your secondary insurance for reimbursement.

I consent to direct billing for my treatments and by signing this hereby state that I will pay any outstanding fees not covered by my insurance company for treatments received.

Signature……..……Date……

Electronic Transmission Authorization and Consent Form

Provider:
MYO CENTRE INC.
13506 – 127 Street NW
Edmonton, AB T5L 1B9
Phone: 780 451-9290

Patient:
Name…….
Address…….
City/Province……
Postal Code……
Phone Number……
Plan Number……
Plan Member Number……..

Consent to Collect and Exchange Personal Information

Message to the Plan Member, Spouse and/or Dependant Regarding Personal Information
Personal information that we collect and disclose about you, and if applicable, your spouse and/or dependants, 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 benefit 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 benefit 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.

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Initials

Additional Consent Applicable to Plan Member Only

- I confirm that I am authorized by my spouse and/or dependants, 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 dependants also authorize the insurer and/or plan administrator and their service provider(s) to disclose information about me, for the purposes of assessing and paying a benefit, I any, and managing the group benefits plan. I also authorize my spouse and/or dependants 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 investigating and prevention of fraud and/or plan abuse.
- If there is an over payment, 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.
- 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 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 and/or dependant, I confirm that I am authorized by the plan member to execute an assignment of benefit payments to the provider.

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Initials

Benefit Assignment Form

I hereby assign benefits 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 the 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 dependant, I confirm that I am authorized by the plan member to execute an assignment of the benefit payments to the provider.

Signature……Date……

Print Name……