Sundance Chiropractic & Wellness
47 Sunmills Dr. S.E.
Calgary, AB T2X 2G6
Off: 403-873-2077 / Fax: 403-873-2076
www.sundancechiro.com

CANCELLATION AND FEE POLICY

Chiropractic

Initial Exam/Treatment	**$85**
Chiropractic Office Visit	**$50**
Shockwave (+$25 each additional body part treated)	**$125**

Therapeutic Massage

30 min. Massage	**$65**
45 min. Massage	**$80**
60 min. Massage	**$95**
90 min. Massage	**$130**

Physiotherapy

Initial Exam/Treatment	**$100**
Physiotherapy Office Visit	**$75**
Shockwave (+$25 each additional body part treated)	**$125**

All prices above include GST if applicable.

This is the current fee schedule for services available at Sundance Chiropractic & Wellness, and may change from time to time with notice. Discounted prices may be available for seniors and students. Please inquire at the reception desk for details regarding other goods or services.

Please note we can direct-bill some insurance companies as well as WCB on behalf of our clients. This is a ***courtesy*** service, and may not be available for some insurance companies and/or some services. Please consult your human resources manager for the specific details regarding your plan.

Please note that the client is always responsible for his or her own account for all services rendered in the event that the insurance company or WCB refuses some or all of the reimbursement.

It is the policy of Sundance Chiropractic & Wellness to charge full fees for missed appointments or for canceling any scheduled appointments with less than 24 hours notice.

Dated this _____day of _____, 20_____

Patient Name (please print) _____

Signature _____

Witness _____

SUNDANCE CHIROPRACTIC & WELLNESS – INFORMED CONSENT FORM

There are risks and possible risks associated with manual therapy techniques used by doctors of chiropractic and physical therapists. In particular you should note:

a) While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures;

b) There are reported cases of stroke associated with visits to medical doctors, physical therapists and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke. Recent studies suggest that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with a cervical manipulation is extremely remote;

c) There are rare reported cases of disc injuries identified following cervical and lumbar spinal manipulation, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal manipulation or other manual treatment;

d) There are infrequent reported cases of burns or skin irritation in association with the use of some types of electrical therapy and shockwave therapy offered by some physical therapists and doctors of chiropractic

I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my physical therapist or chiropractor the nature and purpose of manual treatment in general, (including spinal manipulation), the treatment options and recommendations for my condition, and the contents of this Consent. I consent to the physical therapy or chiropractic treatment recommended to me, including any recommended spinal manipulation. I intend this consent to apply to all my present and future care at Sundance Chiropractic & Wellness.

Dated this_____ day of_____, 20_____.

_____

Patient Signature (or Legal Guardian)

Witness of Signature Name:_____

Name:_____ (please print)

WELCOME TO

Sundance Chiropractic & Wellness

Name:_____**Sex: M___F __Date**: _____

Address:_____**Postal Code**: _____

Email Address: _____(email reminders)

Telephone (Home): _____ (Office): _____ (Cell): _____

Emergency Contact: (name)_____(phone number)_____

Occupation: _____

Marital Status: □ Single □ Married □ Divorced

Birthdate: _____Age:_____Height:_____Weight:_____

Are you a full-time post-secondary student or over 65 years of age? □Yes □ No

School attending? _____ Student ID # _____

How did you find out about us?:_____

Name of Physician referring? _____

CLIENT HEALTH INFORMATION

Present Area of concern:_____

When did this condition begin?_____Is this a Work Injury?_____

Have you had any previous treatment for this condition?_____

What type of care you desire: □Temporary Relief □Corrective Care □Preventive or Wellness Care

Have you been treated for any health conditions in the last year? □ Yes □ No

If yes, please explain:_____

_____

Name of your family physician:_____

Names of specialists currently consulting:_____

List all medications you are presently taking:_____

_____

Please(☑) check any of these professionals you have seen and the **date of visit**.

□ Chiropractor _____ □Naturopath _____

□ Massage Therapist _____ □ Acupuncturist _____

□ Cranio-Sacral Therapist _____ □ Midwife _____

□ Dr. Chinese Medicine _____ □ Other _____

List all Major Surgeries or Operations and when they occurred: □Appendix:_____

□ Tonsils: _____ □ Gall Bladder:_____ □ Hernia:_____

□ Heart: _____ □ Back or Neck:_____ □ Other:_____

List Major Accident or Falls: _____

_____

_____

Please Check (☑) any conditions which are **presently** causing you a problem.
Please **underline** any that have bothered you in the **past**.

General

□ Enlarged Glands
□ Loss of weight
□ Hypoglycemia
□ Nervousness
□ Vision problems
□ Hearing problems
□ Frequent colds or flu

Body systems

□ Frequent urination
□ Painful urination
□ Blood in urine
□ Kidney stones
□ Prostate problems
□ Anemia
□ Hyperthyroid
□ Gas/bloating
□ Constipation
□ Diarrhea
□ Colitis
□ Black/bloody stool
□ Hemorrhoids
□ Liver trouble
□ Gall bladder trouble
□ Eczema
□ Psoriasis
□ Varicose veins
□ Asthma
□ Shortness of breath
□ Heart problems

Musculoskeletal

□ Low back pain
□ Neck pain
□ Arm pain
□ Shoulder pain
□ Elbow pain
□ Wrist pain
□ Leg pain
□ Knee pain
□ Foot pain
□ Pain/numbness down arms or legs
□ Painful tailbone
□ Pain between shoulders
□ Scoliosis
□ Arthritis
□ Difficulty chewing
□ Clicking jaw
□ Ankle swelling
□ Orthopedic problems

Nervous System

□ Vertigo
□ Loss of feeling
□ Dizziness
□ Fainting
□ Headaches
□ Ringing in ears
□ Confusion
□ Depression

Check any of the following you have experienced:

□ Alcoholism
□ Venereal infection
□ Epilepsy
□ Stroke
□ Other _____
□ Arthritis
□ Hypoglycemia
□ Tuberculosis
□ Rheumatic fever
□ Diabetes
□ Cancer
□ Allergies
□ Heart disease
□ High Blood pressure
□ Osteoporosis

Has anyone in your family had any of the following?

□ Heart disease
□ Cancer
□ Other _____
□ High blood pressure
□ Stroke
□ Arthritis
□ Diabetes

Please rate your current level of/or consumption of the following:

	None	Light	Moderate	Heavy	Details
Exercise	□	□	□	□	_____
Sleep	□	□	□	□	_____
Coffee	□	□	□	□	_____
Tea	□	□	□	□	_____
Tobacco	□	□	□	□	_____
Alcohol	□	□	□	□	_____
Junk Food	□	□	□	□	_____
Stress	□	□	□	□	_____
Water	□	□	□	□	_____

Please note that **fees are due as services are rendered**, unless specifically arranged with your health care practitioner. I acknowledge that I am responsible for my account payments upon each visit by Cash, Cheque, Debit, Visa or MasterCard.

NAME_____**DATE**_____