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
47 Sunmills Dr. S.E.
Calgary, AB T2X 2G6

INFORMED CONSENT FOR MASSAGE THERAPY

I understand that therapeutic massage is provided at Sundance Chiropractic & Wellness for the well being of my body and mind. This includes stress reduction, relief from muscular tension, spasm or pain and/or for increasing circulation and energy flow. I agree to communicate with my practitioner at any time I feel my well-being (mental or physical) is being compromised.

I understand that the massage therapist does not diagnose illness, disease or any physical or mental disorders; nor do they prescribe medical treatment, pharmaceuticals or perform chiropractic manipulations.

I acknowledge that massage therapy is not a substitute for medical examinations or diagnosis and that it is recommended that I see a primary health care provider for that service.

I have disclosed all existing medical conditions I am aware of and understand that it is my responsibility to update my therapist of any changes to my health status. <u>I am also aware that a FULL PRICE fee will be charged to me if I do not give 24 hours notice of cancellation.</u>

Date: ______________________

Client's Name (print) ______________________________________

Client's (guardian's) signature ________________________________

Witness of signature: ______________________________________

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
- □ 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

Body systems
- □ Frequent urination
- □ Painful urination
- □ Blood in urine
- □ Kidney stones
- □ Prostate problems
- □ Anemia

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
- □ Arthritis
- □ Hypoglycemia
- □ Tuberculosis
- □ Rheumatic fever
- □ Diabetes
- □ Cancer
- □ Allergies
- □ Heart disease
- □ High Blood pressure
- □ Osteoporosis
- □ Other ____

Has anyone in your family had any of the following?

- □ Heart disease
- □ Cancer
- □ High blood pressure
- □ Stroke
- □ Arthritis
- □ Diabetes
- □ Other ____

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**______________________