Kimberly Rau and Associates
CUSTOM FOOT ORTHOTICS SINCE 1986
Building the Foundation for a Balanced Life

OFFICE USE ONLY Date:_____ CHART NUMBER:_____

Check One: Mr.☐ Mrs. ☐ Miss. ☐ Ms. ☐ Dr. ☐ Rev. ☐ Gender: ( ) male ( ) female

Name: _____ Home Phone: (____)_____

Birthdate: M/___D/___Y/_____Age:___ Work Phone:(___)_____Alt. Phone:(____)_____

Parent/ Guardian (if patient is a dependant):_____Relationship:_____

Address: _____ City:_____ Postal Code:_____
(include unit, apt#, box # OR Fire # and R.R.#)

Permanent Address/Phone # (if different from above):_____

Email Address: _____ Occupation: _____

Emergency Contact Name:_____ Phone #:_____

Referring Health Care Provider: _____ Address/Phone #:_____

Family Physician: _____ Address/Phone #:_____

How did you hear about us? _____Type of Injury/Condition_____

Onset/Injury date: _____Previous relevant injury:_____

Please List any previous *Illnesses or Surgeries*: _____

Current Medications: _____

Do you have *or* have ever had any of the following conditions (check all that apply)

☐ Allergies/Skin Sensitivities
☐ Autoimmune Deficiencies
☐ Cancer (specify) _____
☐ Circulation Problems
☐ Diabetes – (circle type) type I type II
☐ Easy Bruising/ Bleeding
☐ Fracture (location) _____
☐ Other (explain)_____
☐ Kidney Disease
☐ Metal Implant
☐ Heart Problems
☐ Osteoporosis/ Osteopenia
☐ Sprain/ Strains (location)
☐ Stroke
☐ Thyroid Problems
☐ Headaches
☐ Change in vision/hearing
☐ Dizziness/lightheadedness
☐ Weakness
☐ Fatigue
☐ Numbness/tingling
☐ Weight loss/gain

I _____, hereby state that the above information is accurate and true to the best of my knowledge.
Print Name

_____ Date: _____
Signature of Patient or Guardian
(if other than patient please list relationship)

STOP!

IF YOU HAVE ANY OF THE SYMPTOMS LISTED
OR
IF ANY OF THE SCENARIOS BELOW APPLY TO YOU,
YOU ARE ASKED NOT TO COME TO THE CLINIC

YOU WILL NOT BE PENALIZED FOR MISSING YOUR APPOINTMENT

1. Do you have **ANY** of the following new or worsening symptoms or signs?
    a. New or worsening cough
    b. Shortness of breath
    c. Sore throat
    d. Runny nose, sneezing or nasal congestion (in absence of underlying reasons for symptoms such as seasonal allergies and post nasal drip)
    e. Hoarse voice
    f. Difficulty swallowing
    g. New smell or taste disorder(s)
    h. Nausea/vomiting, diarrhea, abdominal pain
    i. Unexplained fatigue/malaise
    j. Chills
    k. Headache
    l. Fever

2. Have you travelled outside of Canada OR had close contact with anyone that has travelled outside of Canada in the past 14 days?

3. Have you had close contact with anyone with an unknown respiratory illness OR a confirmed or probable case of COVID-19?

KIMBERLY RAU & ASSOCIATES INC.
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CONSENT FORM

Rev. JUNE 2020

Patient Name: _____ Chart # _____

Welcome to Kimberly Rau & Associates Inc. We want you to understand and consent to the services we provide to you, the costs involved, and what we do with personal information we obtain about you. Please read the following information and if you have any questions, please ask.

CONSENT FOR TREATMENT

Our health care practitioners are trained professionals licensed by regulatory bodies for their specific profession to provide treatment for health related concerns. Assessment and treatment will include observation and physical examination and possibly casting and fitting of foot orthotics. The treatment services you undergo may be administered by the treating professional and by pedorthic students under the supervision of the treating professional. By signing this form, you agree to our treatment.

CONSENT FOR THE COST OF OUR SERVICES

By signing this form, you agree:

- to pay for all services when they are provided
- if you do not pay for a service at the time it is received, to pay interest on any outstanding balance at the rate of 2% per month and, on default of payment, to pay all costs of recovering the debt, including legal and/or agent costs
- to provide at least **24 hours** notice when cancelling an appointment; because your appointment time is reserved exclusively for you and our professionals cannot use this time to see other patients

Initial _____ (above section read)

CONSENT TO COLLECT AND DISCLOSE PERSONAL INFORMATION

Kimberly Rau & Associates Inc. will collect some personal information about you (including, without limitation, your name, age, contact information, health benefit information, occupational information, personal health information, medical history, etc.) in order to provide you with rehabilitation services and products. A copy of our Clinic Privacy Policy is available which contains additional information about the collection, use, disclosure, retention and accuracy of personal information, steps taken to protect the information, and your right to review your personal information. Please ask if you wish to read/review our Clinic Privacy Policy. By signing this form you agree that:

- Kimberly Rau & Associates Inc. may collect, use, and disclose personal information about you as set out in this form and in our Clinic Privacy Policy
- you understand how our Clinic Privacy Policy applies to you
- you have had an opportunity to ask any questions you have about our Clinic Privacy Policy and they have been answered to your satisfaction
- you understand there are some rare exceptions to the commitments in our Clinic Privacy Policy, as explained in the Policies and Procedures for Personal Information issued by the Government of Canada
- we may exchange (release and receive) your medical records with your attending physician, insurance company, legal representatives, employer, the Workers Safety Insurance Board and any other Health Care Professional relevant to your care

All patients and visitors will be required to wear face masks while inside the facility. Due to the current COVID -19 outbreak, the medical history intake will also include additional screening questions to ensure physical treatment is safe and appropriate. By singing this, you acknowledge that you have answered NO to ALL COVID-19 screening questions.

I have read the Consent Form above and I agree to Kimberly Rau & Associates Inc. collecting, using, and disclosing personal information about me as set out above and in the Clinic Privacy Policy of Kimberly Rau & Associates Inc.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Name (Print): _____ Relationship: _____