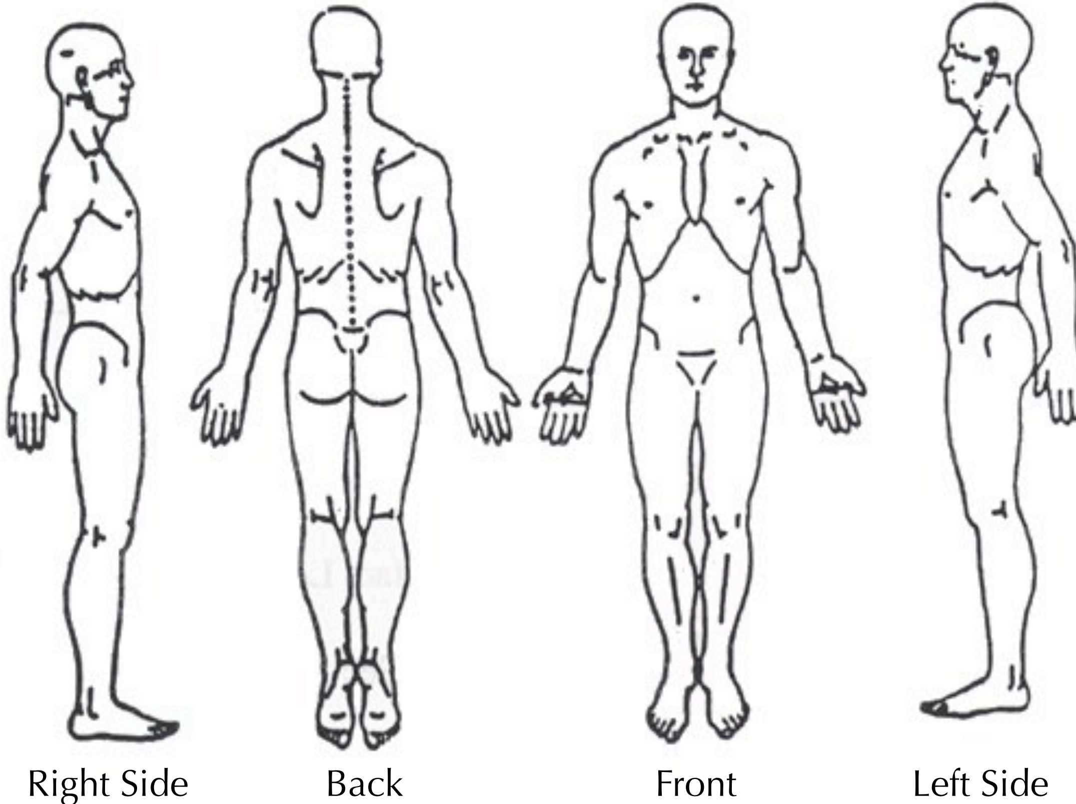
Maple Health Care & Rehab

NAME:____________________________________**DATE:**___________________________

PAIN DRAWING

Please mark on the diagram the area of concern, including all affected areas:



On a scale of 0 to 10, how bad is your pain today?

0	1	2	3	4	5	6	7	8	9	10

No Pain — Moderate Pain — Extreme Pain

For returning or referred clients:

Please list any changes to your health:____________________________________

Any changes to medications:____

Any recent hospitalizations or trauma:____________________________________

10175 Keele Street, Unit 3, Maple, ON, L6A 3Y9 Tel: 905-832-8880 mail@maplehealthcare.com

Maple Health Care & Rehab Fee Schedule

Physiotherapy		Chiropractic	
Initial Exam and Treatment	$90	Initial Exam and Treatment	$90
Subsequent Treatment	$55	Subsequent Treatment	$45
Senior Treatment	$50	Senior Treatment	$40
Shockwave	$75	Acupuncture	$55
Acupuncture	$55	Adjustment plus Acupuncture	$80
K-Tape/Spidertech	$15	Minor Exam/Re-Exam (after >6 months)	$15-30
Pelvic Rehab - Assessment $120, Subsequent $90		Modality (IFC/Ultrasound/Laser)	$15

Massage Therapy				Naturopath	
30 Minutes	$50	(+ HST)	$56.50	Initial - 90 min	$210
45 Minutes	$65	(+ HST)	$73.45	Follow Up - max 30 min	$90
60 Minutes	$85	(+ HST)	$96.05	Acupuncture	$75
90 Minutes	$125	(+ HST)	$141.25		

Chiropody (Foot Specialist)			
Initial Exam and Treatment	$70	Subsequent Treatments	$45
Custom Orthotics	$525	Orthopedic Shoes	$600
Nail Procedures	$200 and up	Footwear Modifications	Varied

Registered Acupuncturist
30 Minutes - $55 // 45 Minutes - $75 // 60 Minutes - $90

Cancellation Policy: 24 hours notice is required to change or cancel your appointment. For non-emergency cases, 50% of the treatment fee will be charged for missed appointments. This policy applies for multiple appointments booked. In most cases insurance companies will not pay for missed appointment fees.

Payment Policy: Once a treatment has been provided you become solely responsible for its payment, which must be paid in full at the time of service. In the event that WSIB, Auto Insurance, or EHC benefits fail to pay for services rendered, you become fully responsible for payment.

I have read and understood the above and agree to abide by these clinic policies.

Signature:_______________________________________

Printed Name:____________________________________

Date:____

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