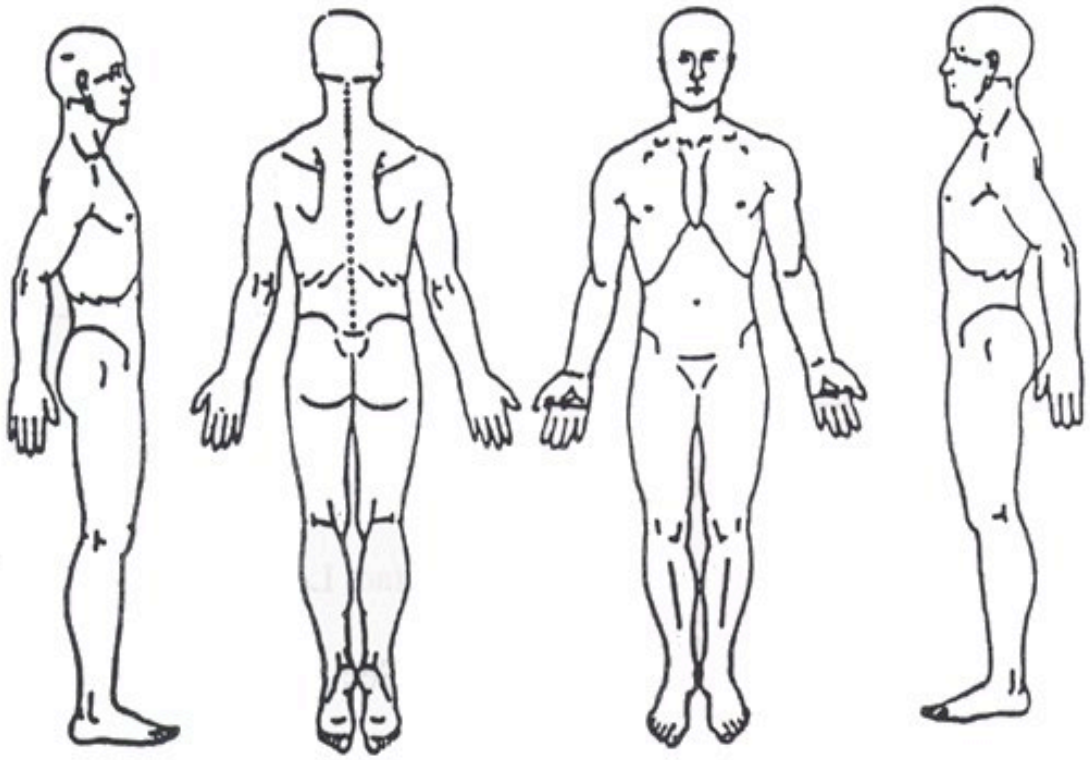
Maple Health Care & Rehab

NAME:_____ **DATE:**_____

PAIN DRAWING

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



Right Side Back Front Left Side

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:_____

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Maple Health Care & Rehab

Clinic Fee Schedule effective March 3, 2025

Physiotherapy

Initial Assessment and Treatment		$119
Re-Assessment or New Condition		$99
Subsequent Treatment		$84
Seniors Treatment		$79
Acupuncture		$84
Shockwave Treatment		$90
Shockwave Additional Body Part		$50

Chiropractic

Initial Assessment and Treatment		$119
Re-Assessment or New Condition		$95
Subsequent Treatment		$60
Seniors Treatment		$55
Acupuncture		$84
Chiropractic plus Acupuncture		$94

Registered Massage Therapy

30 Minutes	$80.00 +HST	$90.40
45 Minutes	$97.50 +HST	$110.18
60 Minutes	$115.00 +HST	$129.95
90 Minutes	$153.50 +HST	$173.46

TCM Acupuncture

Initial Assessment (60 Minutes)			$129
30min $89	45min $109	60min $129	90min $169

Chiropody/Orthotics

Initial Assessment and Treatment		$98
Re-Assessment or New Condition		$83
Subsequent Treatment		$68
FMT treatment	15min $68	30min $99
FMT and Foot Care	30min $115	45min $155
Custom Casted Orthotics		$535
Nail Procedures		$450 and up

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. 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**:_____