

**FEE SCHEDULE & POLICY (OHIP)**

Meditech Rehabilitation Centres Inc. provides the following services:

1. Laser Therapy      2. Massage Therapy      3. Physiotherapy      4. Chiropractic Therapy      5. Exercise Programs

The majority of these therapeutic applications are not covered by OHIP. Private insurance plans, however, may cover some of the services listed above. It is always the responsibility of the patient to pay for treatments provided on the date when these were rendered. The patient, at their discretion, should submit the claim to their insurance carrier for reimbursement.

Initial consultations by physicians are generally covered by OHIP for patients who are Canadian citizens. Occasionally, billing carried out by your family physician and Meditech Rehabilitation Centers Inc. may occur on the same day and one health care professional will not be compensated for the services rendered. Visits on the same day should therefore be avoided.

**Laser Therapy:** (Not covered by OHIP)

- \$ 55.00 for 30 minutes for EACH SYSTEM utilized
- \$ 78.00 for 45 minutes
- \$ 110.00 for 60 minutes

***\*If multiple conditions/areas are being treated at the same time, the number of minutes per system will be totaled to determine cost. (e.g. Both knees treated for 30 mins will be charged \$110.00)***

**Massage Therapy:**

- \$60.50 (30 minutes)
- \$82.50 (45 minutes)
- \$105.00 (60 minutes)
- \$145.00 (90 minutes)

***\*Any massage missed or cancelled with less than 24 hours' notice will be charged at full price for service***

***\*FEEL FREE TO ASK YOUR LASER THERAPIST THE TOTAL COST OF YOUR TREATMENT PRIOR TO INITIATION.***

***Physiotherapy:***

- \$60 Initial Assessment
- \$30 Follow-up assessment

***Chiropractic Therapy:***

- \$60.00 Initial Assessment
- \$30.00 Follow-up assessment

***For patients who prefer privacy, the VIP Room will be available at an additional charge of \$10.00 per visit.***

***NOTE: Appointments must be booked in advance***

**Health Insurance Coverage :**

If you have extended health care benefits, you may be covered under Physiotherapy and/or Chiropractic benefits. Depending upon your specific insurance plan the laser treatments may be covered when therapy is carried out under the supervision of, Nathan Cheung D.C. and David Kunashko D.C., the chiropractors on staff and/or Amr El Gabry, the Registered Physiotherapist. Please check with your insurer to determine your coverage and advise us accordingly (i.e. maximum per year and allowance per visit).

**Payment** – We accept the following: VISA, MasterCard, AMEX, Debit, Cash, or Personal Cheque.

**Kindly check one box:**

- Provide us with your credit card number and expiry date below for pre-authorized payment.**
- Pay after each treatment and you may leave your credit card number and expiry date below for security purposes only.**

I hereby authorize Meditech International Inc. to charge my credit card:

# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ expiry date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

In the name of \_\_\_\_\_ for any unpaid charges.

From time to time I understand that Dr. F. Kahn may make referrals to Meditech Laser Rehabilitation Centre. I further understand that Dr. F. Kahn has an ownership interest in this rehabilitation centre.

I, \_\_\_\_\_, have read the above and fully understand Meditech Laser Rehabilitation Centre's fee schedule & policy and agree to abide by it.

Date

Patient Signature

PATIENT INFORMATION SHEET

Name: \_\_\_\_\_ Sex: M / F Date: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
 Home Phone #: \_\_\_\_\_ Work Phone # / Other #: \_\_\_\_\_  
 EMAIL: \_\_\_\_\_ Dr.'s Name & Ph. #: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Health Card #: \_\_\_\_\_

**HOW DID YOU HEAR ABOUT US?**

Current Health Habits	Yes	No	Patients Comments	Doctor's Comments
Did/do you smoke?				
Did/do you drink any alcohol?				
Are you concerned about your diet?				
Have you been in accidents?				
Current medications? How Long?				
Allergies?				
Exercise regularly?				
Sleeping posture <input type="checkbox"/> side <input type="checkbox"/> stomach <input type="checkbox"/> back				
Females: Are you pregnant?				
Did/do you have cancer? Type?				

Is there a family history of: Heart Disease  Arthritis  Cancer  Diabetes  Other \_\_\_\_\_

Present Complaint: \_\_\_\_\_

Pain or problem started on \_\_\_\_\_

Pains are: Sharp  Dull  Constant  Intermittent

What activities aggravate your condition/pain? \_\_\_\_\_

What activities lessen your condition/pain? \_\_\_\_\_

Is condition worse during certain times of the day? \_\_\_\_\_

Is this condition interfering with your: Work? \_\_\_\_ Sleep? \_\_\_\_ Daily Routine? \_\_\_\_ Other? \_\_\_\_

Is condition getting progressively worse? \_\_\_\_\_

Have you seen any other Doctors for this condition? \_\_\_\_\_

Any effective treatments? \_\_\_\_\_

Have you experienced any side effects from the drugs and surgeries? \_\_\_\_\_

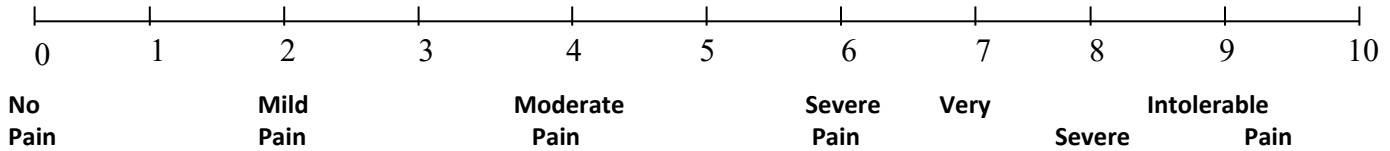
**Other Symptoms:**

<input type="checkbox"/> Headaches	<input type="checkbox"/> Fatigue
<input type="checkbox"/> Visual Disturbances	<input type="checkbox"/> Depression/Anxiety
<input type="checkbox"/> Sleeping Problems	<input type="checkbox"/> Memory Loss
<input type="checkbox"/> Back Pain	<input type="checkbox"/> Fainting Episodes
<input type="checkbox"/> Feelings of Stress	<input type="checkbox"/> Loss of Smell
<input type="checkbox"/> Irritability	<input type="checkbox"/> Loss of Taste
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Gastrointestinal Disturbances
<input type="checkbox"/> Pins and Needles Sensations	<input type="checkbox"/> Ataxia
<input type="checkbox"/> Numbness and Tingling	<input type="checkbox"/> Tinnitus
<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/>

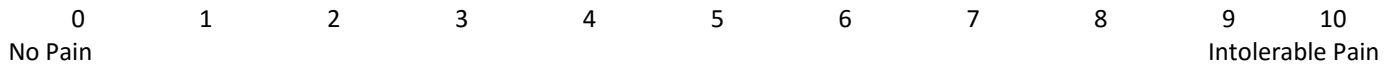
**PATIENT PAIN ASSESSMENT**

Name: \_\_\_\_\_  
Last
First
Date

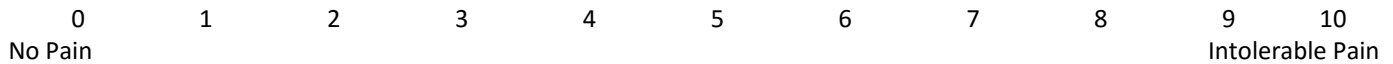
**0-10 Numeric Pain Intensity Scale (1)**



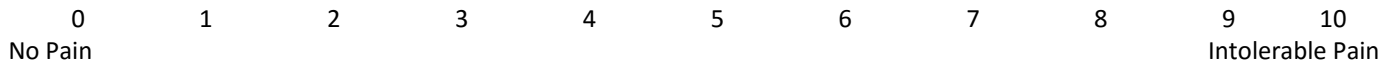
**1) Please rate your pain by circling the one number that best describes your pain at its WORST in the past 24 hours.**



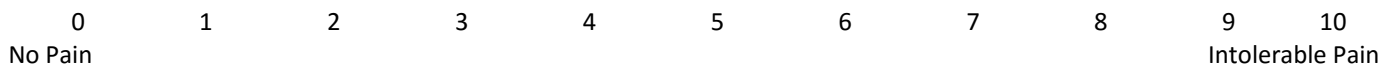
**2) Please rate your pain by circling the one number that best describes your pain at its LEAST in the past 24 hours.**



**3) Please rate your pain by circling the one number that best describes your pain on the AVERAGE.**



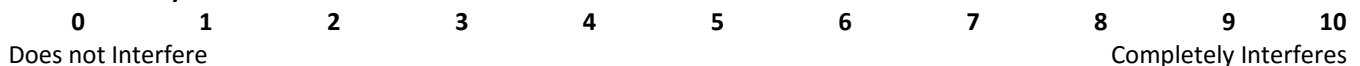
**4) Please rate your pain by circling the one number that tells how much pain you have RIGHT NOW.**



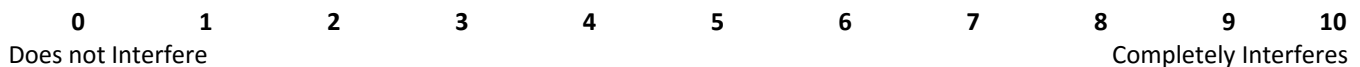
**5) What treatments or medications are you receiving for your pain?** \_\_\_\_\_

**6) Circle the one number that describes how, during the past 24 hours, pain has interfered with your:**

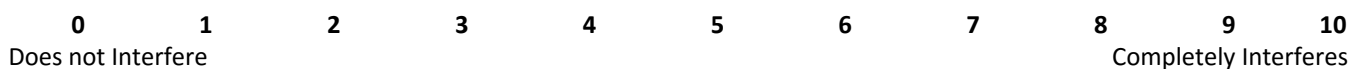
**A. General activity**



**B. Walking ability**



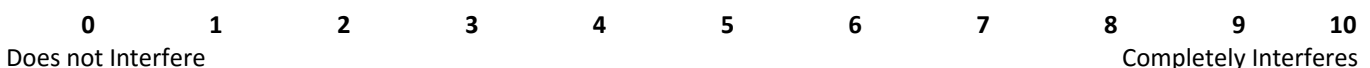
**C. Normal work (includes both work outside the home and housework)**



**D. Sleep**



**E. Enjoyment of life**



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## CONSENT TO LOW INTENSITY LASER TREATMENT

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Low Intensity Laser Therapy (LILT) consists of the use of monochromatic light emission from a Low Intensity Laser Diode (250 milliwatts or less) or an array of high intensity Super Luminous Diodes (providing optical power in the 1000-2000 milliwatt range) to treat musculoskeletal injuries, chronic and degenerative conditions and to heal wounds. The light source is placed in contact with the skin allowing the photon energy to penetrate tissue, where it interacts with various intracellular biomolecules resulting in the restoration of normal cell morphology, function and the enhancement of the body's healing processes.

Low Intensity Laser Therapy improves/cures multiple pathologies with the following objectives in mind, i.e.:

1. Elimination of pain.
2. Reducing or obviating dependence on pharmaceuticals.
3. Restoration of mobility (normal range of motion).
4. Improve quality of life (activity levels, sleep, etc.)
5. Remove the need for surgical intervention in many situations.

Treatments are usually scheduled 2-3 times per week or more frequently in acute cases, at least initially. Subsequent treatments are scheduled in accordance with the patient's physical status. With regard to the number of treatment sessions, these may vary from 1 to 30. A minimum of 5 treatments is recommended. It is important to be aware that before treatment is initiated that the exact number of treatments cannot be predicted. In most cases we expect to see some change in symptomology after 3-5 sessions. There are however exceptions to this rule. Acute injuries generally respond more rapidly than chronic problems and each individual's tissue response varies. Please do not forget that our objective is to minimize the length of treatment and the number of visits. On occasion, however, even our best efforts require multiple treatments, patience and time.

The risk of complications from LILT treatment is substantially less than that associated with many other treatments, medications, and procedures available for the same conditions. It is the practice of our institution to inform patients with regard to these and other matters. Some patients have experienced exacerbation of pain or fatigue subsequent to treatment. If this occurs, utilize pain medication, and/or ice on the area of involvement and notify the doctor/therapist prior to the next treatment. The existence of this phenomenon is due to a sensitive tissue response and protocols will be adjusted accordingly on your next visit. A dull aching sensation subsequent to treatment lasting less than 24 hours indicates that your tissues are reacting positively on the cellular level. Contraindications to treatment include: first trimester of pregnancy and patients on photo-sensitive medications. Laser does not cause cancer, has no cytogenic effect and does not damage tissues.

I acknowledge that I have discussed, or I have had the opportunity to discuss, with my doctor the nature, purpose and procedures of LILT treatment in general, my treatment in particular, alternative treatments and procedures, material risks of those treatments and procedures, the corresponding fee schedule as well as the contents of this consent form. I understand that my clinical information maybe used as part of a clinical study. I hereby give my full consent and permission to use this information solely for the purpose stated. I consent to the low intensity laser treatments offered or recommended to me by my doctor. I intend this consent to apply to all my present and future low intensity laser treatments.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature/Legal Guardian

\_\_\_\_\_  
Guardian Relationship to Patient

\_\_\_\_\_  
Printed Name

## PATIENT COMPLIANCE – THERAPEUTIC IMPLICATIONS

At this time, we wish to emphasize a number of factors regarding the administration of Laser Therapy.

The therapy team that attends to your medical problems will advise you regarding the frequency and duration of treatments. This may vary from one patient to another and also with respect to the condition being treated.

For travel and work reasons deviations from the treatment schedule are permissible. Generally, however, patients are advised to follow the course of treatment outlined, in order to produce optimal clinical outcomes. Significant deviation from that course can impede the healing process.

Our experience over the course of almost twenty years has proven conclusively that patients who comply with their prescribed therapeutic schedule achieve their objectives more rapidly than those who do not.

Once again, in order to achieve maximum benefit, patients must be encouraged to follow the treatment schedule outlined by the healthcare professional managing their case.

- Allowances with regard to frequency of treatments may be made depending on geographic considerations and the time factor involved. For best outcome however, a relatively structured therapeutic programme is essential.
- In some patients, improvement may be evident after only 1-2 treatment sessions, in others however, secondary to genetic factors, chronicity, etc. 8-12 treatments may be required before significant improvement is experienced.
- It is always stressed that patients should adhere to the programme recommended, in order to achieve the desired objective.
- Adverse effects resulting from Laser Therapy are negligible and are not significant in our extensive experience. Nevertheless, if any should occur bring them to the immediate attention of the medical staff in order that the therapy may be modified accordingly.
- It is essential that patients be reassessed by the healthcare professional directing their therapeutic programme every 2-4 visits, to effect protocol changes that will advance the healing process.
- Customization of the protocols for each individual patient is an important aspect of Laser Therapy.
- If patients need to be seen more frequently by the supervising clinician, they should so indicate when registering or notify the attending therapist, prior to the initiation of treatment.

**Fred Kahn, M.D., F.R.C.S.(C)**

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