Fax: 1.403.475.1129
Email: admin@webclinic.ca
Toll Free Phone: 1.844.932.3627

Note: Please save this form to your computer before you start filling in the fields.

If you wish to fill out this PDF-formatted form on your computer you can download **Adobe Reader** for free on the Adobe website.

If you would like to reset your complete form, please click on this button → Reset Form - Deletes all entries

Private Assessment

Please indicate if any of the following applies to you:

☐ **I am 25 years or older OR I am 18 years or older and have been diagnosed with a severe chronic disease** (such as: Cancer, Epilepsy, autoimmune diseases, Multiple Sclerosis, Fibromyalgia, Crohn's, etc.)

☐ **I can provide proof that I have undergone conventional treatments** (therapies and prescription medications) **for at least 6 consecutive weeks in the past 5 years for my primary medical condition**

Medical Records

1) You have to submit medical records from **all applicable specialists and physicians** pertaining to and supporting main diagnosis together with the completed private assessment document **in order to be scheduled for an appointment.**
2) Medical records have to state or confirm your official diagnosis.
3) Medical records refer to: Recent investigations and consultation (specialist) reports, diagnostic imaging reports, medication history (updated cumulative patient profile is acceptable) and prior treatments.

- If you do not have access to medical records and would like us to obtain them on your behalf please complete the "release of medical records" form on page 6. There is an administrative fee for this service of $24.95 plus any fees charged by your clinic. A typical doctor's clinic charge for medical records is $25-$50[1].
- If you would like to obtain medical records yourself the quickest and easiest way to obtain them is to arrange an appointment at your family physician's or specialist's office and ask them to print off ONLY the records required to substantiate the medical condition for which you want to be assessed.

If you have and questions regarding the required records, have not seen a physician for diagnosis, or there are no existing medical records for your primary medical condition please contact us at: 1-844-932-3627 or via email at admin@webclinic.ca.

Prescription History

1) We need an official prescription history to be submitted with this document. You can obtain this directly from your pharmacy or prescribing doctor.

[1] https://www.albertadoctors.org/leaders-partners/health-info-and-privacy/HIA-fee-schedule

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AN ASSESSMENT APPOINTMENT WILL BE SCHEDULED ONCE ALL REQUIRED MEDICAL RECORDS AND DOCUMENTS HAVE BEEN RECEIVED AND REVIEWED.

You can send us your records (private assessment document + medical records + official prescription history) via one of the following methods:

- **Email:**
  - Email your scanned or digital copy as an attachment to **admin@webclinic.ca.** Indicate your surname and the words "Private Assessment" in the subject line.
- **Fax:**
  - Fax the records to **403-475-1129** with a cover page of your name and the words "Private Assessment".
- **Courier, Mail or Hand Delivery:**
  - To courier, mail or hand deliver your records, please send your files to: **" WebClinic.ca, Suite 503 - 326 11th Ave SE, Calgary, AB T2R 0C5**" or check our website for details at webclinic.ca

In order to provide you with the fastest and most convenient access to your private assessment you get to **video conference** from the comfort of your home at no additional cost.

To guarantee a fast processing of your forms please read all of the following forms carefully and complete them to the best of your knowledge and understanding. The complete document contains X parts:

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PART 1: GENERAL REGISTRATION

PATIENT NAME – hereafter "the patient"

First Name	Middle Name	Last Name (Surname)

ADDRESS

Address

City	Province	Postal/ZIP Code

CONTACT INFORMATION

Home phone	Cellphone	Work/Other Phone
☐ You can leave voicemails	☐ You can leave voicemails	☐ You can leave voicemails

Email Address

GENERAL INFORMATION

Date of Birth

Year	Month	Day

Marital Status

◯ Single ◯ Married ◯ Divorced ◯ Separated ◯ Widowed

Occupation

Are you a veteran?

◯ Yes
◯ No

Valid Health Care Number

Gender

◯ Male ◯ Other
◯ Female

PART 2: THERAPIES AND TREATMENT HISTORY

REASON FOR ASSESSMENT

☐ Chronic Pain Condition ☐ Mental Health Condition ☐ Seizure Disorder ☐ Sleep Apnea
☐ Auto-Immune Disease ☐ Gastro-intestinal Disorder ☐ Cancer ☐ Other:_____

PRIMARY (MAIN) DIAGNOSIS

SECONDARY DIAGNOSES

CONVENTIONAL TREATMENTS HAVE BEEN TRIED

☐ Yes ☐ No

PLEASE INDICATE A HISTORY OR PRESENCE OF

☐ Active or unstable cardiovascular disease
☐ Uncontrolled hypertension
☐ Pregnant, nursing, or trying to get pregnant
☐ Psychotic disorder (including schizophrenia)
☐ Problematic substance use or dependence
☐ Asthma / COPD

LOCATION OF (CHRONIC) PAIN

If you are suffering from pain please explain below at what locations you feel pain. Indicate the sensation you feel by referring to the key.
For example: Severe Stabbing Pain in right shoulder (5-7)

Key:
Pain Descriptors: Stabbing, Burning, Pins & Needles, Numbness, Aching
Pain Level: **0 – No Pain.**
1 – Mild pain. You are aware of it, but it doesn't bother you.
2 – Moderate pain. You can tolerate it without medication.
3 – Moderate pain that requires medication to tolerate.
4-5 – More severe pain. You begin to feel antisocial.
6 – Severe pain.
7-9 – Intensely severe pain.
10 – Most severe pain. It may make you contemplate suicide.

LIST OF MEDICATIONS

Please list all current prescription medication you are taking. **Note:** This does not replace an official Prescription History

Medication	Dosage	Frequency

SURGICAL HISTORY

Please list all surgeries you have undergone, including their dates:

Surgery	Date

NON-SURGICAL TREATMENTS

Check all non-surgical treatments you have used or are using for your medical condition(s):

- ☐ Physical therapy
- ☐ Injections
- ☐ Rheumatologist
- ☐ Social Worker
- ☐ Psychiatrist
- ☐ Orthopedist
- ☐ Oncologist
- ☐ Endocrinologist
- ☐ Surgeon
- ☐ Neurologist
- ☐ GI Specialist
- ☐ Pain Specialist
- ☐ Other, please specify:_____

THERAPIES AND TREATMENT HISTORY

List and explain all conventional therapies that you have attempted to date to assist you with the management of your medical condition(s). Explain how these treatments have or have not been successful:

Please Note: If you require more space to explain your therapy history, please continue on an additional document and attach it to this document.

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RELEASE OF MEDICAL RECORDS

Webclinic is representing the patient indicated below and has been designated to assemble, review, process medical information, and schedule appointments related to the inquiries for the patient indicated on this form. The request for release of medical records pertains only to the records related to the specific medical condition in which the patient requires the release.

<u>This is NOT a request to change physicians</u>.
This request is to release patient records for the medical conditions, as stated on the fax coversheet, only.

Date:

Name of releasing Physician:

Releasing Physician Phone:	Releasing Physician Fax:

Patient Name (legal name as it appears on patient label):

DOB (yyyy/mmm/dd):

/ /

Releasing to Webclinic.ca.

I, _____, hereby authorize you to release my / my family's medical file(s) and any pertinent information regarding my / our health while under your care.

_____
Patient signature

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PART 4: PAYMENT AUTHORIZATION FORM

WebClinic.ca provides the service of private medical assessments, appointment scheduling, requesting medical records and telemedicine appointments.

I wish to pay for WebClinic.ca services as outlined below with: Credit Card Cheque

Currently WebClinic.ca does not accept Visa Debit, Debit, E-Transfer or PayPal. If you would like to pay via cheque please send a cheque for the full amount, payable to WebClinic.ca to: "WebClinic.ca, Suite 503, 326 11th Ave SW; Calgary, AB T2R 0C5"

CARDHOLDER INFORMATION (as it appears on your card) - ☐ Same as Patient Name and Address

First Name	Last Name	
Address		
City	Province	Postal/Zip Code

CREDIT CARD INFORMATION

Credit Card Type	Credit Card Number	
☐ Visa ☐ MasterCard		
Expiry Date	CVC Number (3-digit number on back of card)	Email address for online receipt
/		

FEES TO BE PAID – all fees in Canadian Funds	**Complete Package**	**Assessment only**
Initial Assessment In-Clinic or Video Conference	199 + GST 9.95 = **208.95***	199 + GST 9.95 = **208.95***
Medical Record Collection A $25 retainer will be charged when fees are processed. This retainer will be used towards any cost charged by your clinic for the transfer of records. If the fees are less than $25 you will be reimbursed the remainder. If the fees exceed $25 you will be charged for the additional cost.	24.95 + GST 1.25 + 25 Retainer = **51.20***	Supplied by patient
Authorized amount to charge for this transaction only:	☐ **260.15***	☐ **208.95***
	I want WebClinic.ca to collect my medical records for me.	I will supply my medical records together with this document.

*GST included

I hereby authorize **WebClinic.ca** to charge the agreed-upon amount above to my credit card provided herein. I agree that I will pay for this purchase in accordance with the issuing bank cardholder agreement. I understand that this payment is non-refundable.

CARDHOLDER – SIGN AND DATE BELOW

Cardholder Signature _____ Date _____

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PART 5: DOCUMENT CHECKLIST

Please ensure that all of the following is completed and attached to your application. If you have any questions or need assistance please contact us at **1-844-932-3627** or via Email at **admin@webclinic.ca**.

- ☐ General Registration
- ☐ Therapies and Treatment Forms
- ☐ Medical Records **OR** Medical Records Release Form
- ☐ Payment Authorization
- ☐ Official Prescription History