

## PHYSIOTHERAPY CONSENT FORM

### CONSENT TO TREAT AND CONSENT TO COLLECT AND DISCLOSE INFORMATION:

In accordance with the Federal Government's Personal Information Protection and Electronic Documents Act (PIPEDA) effective January 1, 2004, Elevation Physiotherapy & Wellness needs your informed consent to provide assessment and treatment services to you and to collect and use your personal information. We want you to understand the services we provide, the cost involved, and what we may do with your personal information.

1. CONSENT TO TREATMENT:

I agree to participate in assessments and treatments given by the Physiotherapist. I understand that the assessment and treatment services I undergo will be administered by the treating Physiotherapist. I acknowledge my Physiotherapist has given me information that is pertinent to my assessment and treatment, including the possible risks and side effects of the proposed treatment.

Initial: \_\_\_\_\_

2. CONSENT FOR THE COST OF OUR SERVICES:

I agree that I have been informed of the costs of the assessment and follow-up treatments/ services provided to me. I understand that Elevation Physiotherapy & Wellness may under some circumstances bill these services to my insurance company or a third party responsible for the payment and that I am responsible for paying the full balance of any amount not thus covered. I also understand that I will be billed for all the services rendered that may not be covered at all by the insurance company.

Initial: \_\_\_\_\_

3. CONSENT TO COLLECT AND DISCLOSE INFORMATION:

Personal information that Elevation Physiotherapy & Wellness collect, retain, use and disclose may include without limitation your age, contact information, occupational information, personal health information, medical history and other information deemed necessary to fulfill the following purposes:

- a. To provide physiotherapy assessment and treatment services.
- b. To provide/obtain to/from Third Party Payers, Physicians and Legal Counsel with/from progress reports, assessment findings, diagnostic tests or medical investigations, resulting from the services provided to you or in order to optimize the treatment to be provided to you.
- c. To contact you about services you have received or services we are offering. This may include follow-up calls or appointment reminders, newsletters, notices of special events.

Initial: \_\_\_\_\_

4. I hereby request and consent to the performance of physical assessment/ treatment procedures on me by the Registered Physiotherapist identified below. My consent is voluntary and I intend this consent form to cover the entire course of assessment/ treatment for my present condition, commencing on the date indicated below.

Lynda McClatchie, PT, MScPT, CertMDT  
Reg. #: 09286

CONSENT TO ASSESSMENT, TREATMENT AND DISCLOSING PERSONAL INFORMATION

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**CANCELLATION POLICY**

Each physiotherapy appointment is booked one-on-one with our Physiotherapist and that time is reserved for you. Please be advised that we have a **Cancellation Policy** in effect.

You **MUST** give 24 hours notice to cancel your appointment. Any missed or cancelled appointments without the required 24 hours notice will be charged a \$35 cancellation fee.

This fee is not eligible to be reimbursed by your extended health coverage provider. You will be eligible for covering this cost.

I, \_\_\_\_\_, have read and understand Elevation Physiotherapy & Wellness's Cancellation Policy. I am aware that, should I not give 24 hours of notice to cancel my appointment, I will be invoiced a \$35.00 fee.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Elevation Physiotherapy & Wellness Staff Signature