

2340 Council Ring Road, Unit 105 Mississauga, Ontario, L5L 1C1 (905) 607-3538

info@elevation-physio.com www.elevation-physio.com

PHYSIOTHERAPY CONSENT FORM- Please read carefully

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 ervices olved,

to you and to	104, Elevation Physiotherapy & Wellness needs your informed consent to provide assessment and treatment se to collect and use your personal information. We want you to understand the services we provide, the cost invo 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. Pelvic Floor Consent (if appropriate): I understand that an internal assessment of the functioning of my pelvic floor may be deemed appropriate and there may be an internal component (vaginal/rectal) to the assessment and/or treatments. When this is the case, it will be discussed with me before proceeding and I may grant or refuse consent. I understand that I may rescind consent at any time.

Potential risks of doing an internal examination:

Spotting Skin reaction (from lubrication)

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Initial:			
5. COVID-19 : While Elevation regarding the safety of both sterile environment. We are staff, but there is a risk of at the clinic. While receiving physical distancing guideling clinicians and staff will weak surfaces after each appoint caution, it is our recommendation.	th patients and staff to the trying to provide the exposure to a carrier ag services, your cliniones to assess and treater a mask and gloves the treater.	o prevent any exposure the best environment position of the virus if you attercian may be closer than at each patient. Please of the duration of treatment spaces are individual.	to COVID-19, this is not a sible for our patients and in-person appointments the recommended wear a mask. Our tment. We sanitize all ual. In an abundance of
 I hereby request and consent of Registered Physiotherapist identifier the entire course of assessment below. 	entified below. My cons	ent is voluntary and I inten	d this consent form to cover
Lynda McClatchie, PT, MScPT, CertMDT Reg. #: 09286	Jacqueline Fiorali, PT Reg. #: 16625	Keri Edwards, RMT Reg. #:P298	Joelle Li Yuen Fong PT Reg #: 18076
CONSENT TO ASSESSMENT, TREATME	NT AND DISCLOSING PER	RSONAL INFORMATION, an	d COVID-19 RISK
Print Name		Signature	
Date			
CANCELLATION POLICY Each physiotherapy appointment is for you. Please be advised that we You MUST give 24 hours notice to the required 24 hours notice will be This fee is not eligible to be reimbur cover this cost.	have a Cancellation P cancel your appointme e charged a \$35 cance	Policy in effect. ent. Any missed or cance llation fee.	elled appointments without
I,	n aware that, should I	read and understand Elev not give 24 hours of noti	vation Physiotherapy & ice to cancel my
Print Name		Signature	

Miscarriage with pregnancy

Urinary tract infection

Pain/discomfort

Emotional stress