

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, ReAlign Health 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 and the support personal. I understand that the assessment and treatment services I undergo may be administered by the treating provider and by the support staff under the supervision of the treating provider. I acknowledge that my treatment provider has given me information that is pertinent to my assessment and treatment, including the possible risks and side effects of the proposed treatment.

Initial:	
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2. CONSENT FOR THE C	OST OF OUR SERVICES

I agree that I have been informed of the costs of the assessment and the treatments/services provided to me. I understand ReAlign Health 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 in full the 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. Fees per service unit (15 mins) \$30.00

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3. CONSENT TO COLLECT AND DISCLOSE INFORMATION:

Personal information that ReAlign Health collects, 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:

To provide assessment and treatment services.

progress reports, assessment findings, diagnostic tests/medical investigations, resulting from the services provided to you or in order to optimize the treatment to be provided to you. 3. To contact you about services you have received or services we're offering. This may include (without limitation); follow-up calls or appointment reminders, newsletters, notices of promotions and special events.							
Initial:							
I hereby request and consent to the performance of physical assessment/treatment procedures on me by the Registered Physical Therapist identified below and the support staff. 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.							
Initial:							
Matt Welsh Registered Physiotherapist							
PT Signature	Print		Date				
Patient Signature	Patient Print Name		Today's Date				
Cancellation Policy							
Please be advised that we have a Cancellation Policy in effect. You MUST give 24 hours of notice to cancel your appointment. Any missed or cancelled appointment within 24hrs will be charged \$25.00 cancellation fee. The fee is not eligible to be reimbursed by your extended health provider. You will be responsible for covering this cost. If you have any questions or concerns, please discuss this matter with the front desk.							
I,, understand and agree with the ReAlign Health cancellation Policy. I am aware that, should I not give 24 hours notice to cancel my appointment, I will be invoiced a \$25.00 fee.							
Patient Signature		Date					