MVA CONSENT FORM

Patient Name (please print): _____

Parent/Guardian Name (if appropriate): _____

Summerside Children's and Sport Physiotherapy

Consent to Examination and Treatment

I hereby direct and authorize Summerside Children's and Sport Physiotherapy Ltd., the physiotherapist and physiotherapist assistant employed or associated therewith, permission to conduct interview, examination, treatments and other procedures, which in the opinion of the physiotherapist may be appropriate.

_____ _____

Date Signature

Consent to Release of Medical Information

I also authorize Summerside Children's and Sport Physiotherapy Ltd. and my attending physiotherapist to release such medical information which may have or have had access to, including but not restricted to: medical history, symptoms, x-rays, diagnosis, treatment, prognosis, medical opinions, medical records, the results or conclusions of any tests of any kind to my physician and/or other invested parties, and to provide reports to said agencies as requested.

_____ _____

Date Signature

Fee Schedule

If your claim is accepted "within diagnostic protocols", the fees for your initial visits will be direct billed to your insurance company, with no direct cost to you. Your therapist can explain this further, and whether or not you qualify to be treated within protocols. If you are treated "outside of protocols", or are asked to pay for treatments and then submit for re-imbursement, all documentation will be provided for re-imbursement from any extended health benefits you may have. Please note that Community Rehab funding (formerly known as Alberta Health Care) does not cover any visit relating to a Motor Vehicle Accident. The "Out of Protocols" treatment rates are as follows:

Assessment (45 minute booking): $120.00
Treatment (30 minute booking): $85.00

We understand that your schedule may change and, from time to time, you may need to cancel your appointment. However, **we require 24 hours notice for any cancellation**; failure to do so will result in a $20 cancellation fee.

_____ _____

Date Signature

TO BE COMPLETED AT THE END OF THE FIRST VISIT

Consent To Treatment Plan

My Physical Therapist has provided me with information regarding the following:

- the diagnosis, as known
- the physical therapy treatment being suggested
- significant risks, benefits of treatment and alternatives to this treatment
- reasonable additional procedures which may be necessary,
- the potential risks of foregoing the suggested care
- the importance of my participation in the treatment and the home program suggestions.

I understand the information as verbally provided and give my consent to the treatment plan as suggested.

_____ _____

Date Signature

Summerside Children's and Sport Physiotherapy

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Contact Information

Name of Patient: _____ Date of Birth: _____

Alberta Health Care number: _____ Gender: Male Female

Address: _____

City: _____ Postal Code: _____

Home Phone: _____ Work/Cell Phone: _____

Email: _____

May we send you a copy of our newsletter via email? □ Yes □ No

Contact Person and Relationship: _____

Contact Person Phone Number: _____

Family Doctor: _____

Referring Doctor: _____

Do you have any pre-existing Medical Conditions **other than** what you are seeking treatment for today?

_____

_____

Insurance Information

Insurance Company:_____ Contact Person:_____

Phone Number: _____ Fax: _____

Policy or Claim Number:_____ Date of Accident:_____

Do you have extended health benefits that cover physiotherapy? □ **Yes** □ **No**

Benefits Carrier: _____

How did you hear about our clinic? Please check all that apply and be as specific as possible so that we can thank them appropriately!

❒ Friend/Family: _____

❒ Dr Recommended: _____

❒ Web Search: _____

❒ Other: _____

❒ Been here before

❒ Facebook

❒ Driving By

❒ Live in Neighborhood