Summerside Children's and Sport Physiotherapy

WCB Consent Form

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 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 to provide reports to said agencies as requested.

_____ _____

Date Signature

Consent to Bill

I authorize Summerside Children's and Sport Physiotherapy Ltd. to report my progress and attendance to the WCB. If my claim is denied, I understand that it is my responsibility to pay for any services provided beyond the initial assessment and first treatment. If you choose to proceed with treatment before your WCB claim has been accepted, please note that it will be at a rate of $65 for ½ hour treatment and will be reimbursed upon acceptance of your claim.

_____ _____

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
- The risks, benefits, and alternatives to this treatment
- Reasonable additional procedures which may be necessary
- The potential risks of foregoing suggested care
- The importance of my participation in the treatment and 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

WCB Consent Form

Claim Information:

Name of Patient: _____ Date of Birth: _____
WCB Claim #: _____ Alberta Health Care #: _____
Date of Injury: _____
What is your injury? _____

Patient Contact Information:

Home Address:_____
City: _____ Postal Code:_____
Home Phone: _____Work Phone: _____
Email: _____ May we send you a copy of our newsletter via email? □ Yes □ No
Contact Person and Relationship: _____
Contact Person Phone Number: _____
Do you have any pre-existing Medical Conditions? Please describe.
_____
_____
_____

Employer Information:

Employer: _____ Employer Phone: _____
Employer Address: _____
_____
Job Title at the Time of Accident: _____
Clinic/doctor you first went to after accident:_____ Date of visit: _____

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