GENERAL CONSENT FORM

Summerside Children's and Sport Physiotherapy

Patient Name (please print): _____

Parent/Guardian Name (if appropriate): _____

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

Consent to Bill and Cancellation Fee

I authorize Summerside Children's and Sport Physiotherapy Ltd. to contact and bill the appropriate funder for physiotherapy services, as requested. Direct Billing will be offered whenever possible, however may not be available in all cases.

I also understand that any cancellation of a booked appointment with less than 24 hours notice, or failure to attend a booked appointment visit, will result in a $20 Cancellation Fee that must be paid prior to my next appointment.

_____ _____

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

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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?

_____

_____

_____

Is this injury work related? □ **Yes** □ **No** Is this injury related to a Motor Vehicle Accident? □ **Yes** □ **No**

Have you had physiotherapy on this body part since April 1st? □ **Yes** □ **No** If so where? _____

Would you consider yourself "Low Income" (government subsidy, temporary hardship, etc)? □ **Yes** □ **No**

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

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