Glen Abbey Physiotherapy

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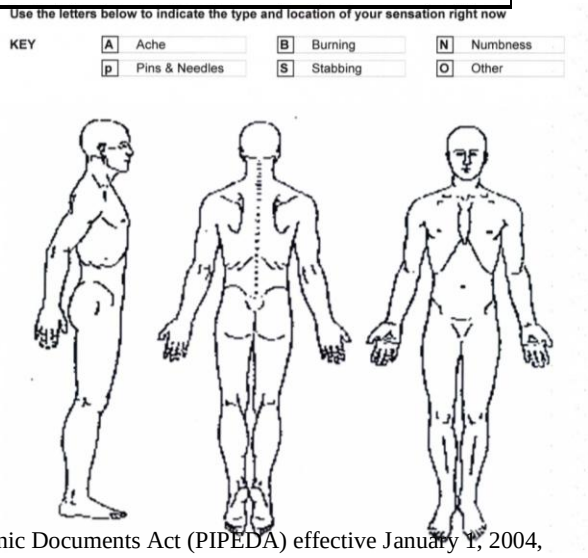
PHYSIOTHERAPY INTAKE FORM

Name:		**Date of Birth**	Day	Month	Year
Street Address:		**City**		Postal Code	
Email Address:		**Cell #:**			
Appointment reminder?	TEXT or EMAIL	**Referring MD:**			
Health Card #		**Profession:**			
How did you hear about us? (Circle)	GOOGLE WEBSITE REFERRAL_____ OTHER: _____				
Emergency Contact Info	NAME: NUMBER:				

Insurance Company Name:			
Group/Policy #			
Certificate / I.D. #			
Ins. Policy Holder			
Policy Holder DOB	Day	Month	Year

Additional Info:



PHYSIOTHERAPY CONSENT

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, Glen Abbey Physiotherapy 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.

2. CONSENT FOR THE COST 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 Glen Abbey Physiotherapy 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 assessment/re-assessment $100.00, and treatment service follow-up $70.00.*

3. CONSENT TO COLLECT AND DISCLOSE INFORMATION:

Personal information that Glen Abbey Physiotherapy 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:

1. To provide assessment and treatment services.
2. To provide/obtain to/from Third Party Payers, Physicians and Legal Counsel with/from 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 even

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.

I CONSENT to the ASSESSMENT, TREATMENT, COST, and to DISCLOSE PERSONAL INFORMATION by signing below.

Patient Signature, _____ Date _____

Vinaya Chitgopkar, RPT, _____ Date _____