**BodyCheck Prevention & Health Physical Therapy Centre**

**Consent Form & Payment Agreement**

NAME:

FIRST INITIAL LAST

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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CITY PROVINCE POSTAL CODE

TELEPHONE: Home: Work: Cell:

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ALBERTA HEALTH CARE #: \_\_ \_\_ \_\_ \_\_ \_\_ - \_\_ ­­\_\_ \_\_ \_\_

NINE DIGITS

DATE OF BIRTH: AGE: MALE: FEMALE:

MONTH/DAY/YEAR

FAMILY or REFERRING PHYSICIAN:

\_\_\_\_\_ I understand that the cost of PHYSICAL THERAPY treatment at this clinic is not covered by

Initials Alberta Health Care, Alberta Health Services or Workers Compensation Board. I understand that payment is due at the time of the appointment and the fee is set per 30-minute session(s). Fees for reports will be billed separately.

­­­\_\_\_\_\_ I understand that I am responsible for all fees incurred at the clinic associated with my

Initials treatment program and agree to pay any and all outstanding balances on my account. I am aware that there is a cancellation policy in effect. A minimum notice of 24 hours is required to cancel an appointment otherwise you will be charged.

\_\_\_\_\_ I consent to undergo physical therapy assessment, investigations and treatments, if they are

Initials required, as are deemed necessary and are prescribed by my therapist. I understand that I have the right to be informed of the treatment techniques chosen and of the risk vs. benefit of the techniques prior to them being administered. I maintain the right to choose not to have certain techniques performed. I understand that my privacy will be respected as outlined in the Privacy Act Brochure.

\_\_\_\_\_ I also consent to the exchange of information regarding my assessment and treatment with my

Initials family doctor and/or specialist for the purpose of enhancing my treatment and rehabilitation. Any exchange of information with third party insurers and lawyers will only occur with a current (within the past six months) written release signed by myself.

Please sign below in acknowledgement, understanding & acceptance of this agreement:

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If under 18 years of age, must be signed by a parent or legal guardian