VAUGHAN PHYSIOTHERAPY CLINIC

Address: 398 Steeles Ave. West Unit 201, Thornhill, ON, L4J 6X3
Phone: 905 669 1221
Fax: 905 669 6995
Email: info@vaughanphysiotherapy.com
Web: vaughanphysiotherapy.com

Client Information:
Please fill in the following information as accurately as possible. Let us know if you require any assistance.

Prefix:	☐ **Mr.** ☐ **Mrs.** ☐ **Ms.** ☐ **Other:**		
First Name:		**Last Name:**	
Date of Birth (yyyy-mm-dd):		**Phone Number:**	
Address:		**Email:**	
City:		**Postal Code:**	
Occupation:		**Employer:**	
What is your preferred method of contact:	☐ **Text Message** ☐ **Phone** ☐ **Email**		

Insurance:
Please provide any relevant insurance information to our front desk so that we may help you with the claims process.

Will you be using Extended Health Coverage Insurance?	☐ **Yes** ☐ **No**
Are you seeking treatment related to being involved in a work injury through the Workplace Safety and Insurance Board (WSIB)?	☐ **Yes** ☐ **No**
Are you seeking treatment related to being involved in a Motor Vehicle Accident (MVA)?	☐ **Yes** ☐ **No**

Assessment and Treatment Consent

I GIVE PERMISSION FOR THE HEALTH CARE PROVIDER AT VAUGHAN PHYSIOTHERAPY CLINIC TO ASSESS MY CONDITION(S) AND TO PROVIDE THE APPROPRIATE CONSULTATION AND TREATMENT(S). TREATMENT OPTIONS CAN INCLUDE: EDUCATION, MANUAL AND HANDS-ON THERAPY, INCLUDING SPINAL MANIPULATION, ELECTROTHERAPEUTIC MODALITIES, PAIN RELIEVING AGENTS, EXERCISES, TAPING, BRACING, CUSTOM FOOT ORTHOTICS AND ACUPUNCTURE. I WILL BE INFORMED OF MY OPTIONS, INCLUDING THEIR BENEFITS, SIDE EFFECTS AND POTENTIAL COMPLICATIONS, PRIOR TO APPLICATION. I HAVE THE RIGHT TO QUESTION, WITHDRAW, DENY OR REJECT ANY TREATMENT OPTION AT ANY TIME DURING MY TREATMENT PROGRAM.

☐ I have read and understood, and consent to the above
Initials: _____

E-Communications

I GIVE PERMISSION FOR VAUGHAN PHYSIOTHERAPY CLINIC AND MY HEALTHCARE PROVIDER(S) TO COMMUNICATE WITH ME THROUGH ELECTRONIC MESSAGES. THIS INCLUDES UPCOMING APPOINTMENT REMINDERS, RECEIPTS, ACCOUNT STATEMENTS AND OTHER RELEVANT COMMUNICATION. I UNDERSTAND THAT I MAY OPT-OUT OF E-COMMUNICATION AT ANY TIME, BUT IN DOING SO, IT WILL AFFECT MY ABILITY TO RECEIVE THE PREVIOUSLY MENTIONED.

☐ I have read and understood, and consent to the above
Initials: _____

Consent to Collect and Exchange Personal Information and Benefits Assignment Form

I AUTHORIZE THE INSURER AND/OR PLAN ADMINISTRATOR AND THEIR SERVICE PROVIDER(S) TO:

- USE MY PERSONAL INFORMATION FOR THE ABOVE PURPOSES
- EXCHANGE PERSONAL INFORMATION WITH ANY INDIVIDUAL OR ORGANIZATION, INCLUDING HEALTHCARE PROFESSIONALS, INVESTIGATIVE AGENCIES, INSURERS AND REINSURERS, AND ADMINISTRATORS OF GOVERNMENT BENEFITS OR OTHER BENEFITS PROGRAMS WHEN RELEVANT FOR THE ABOVE PURPOSES.
- EXCHANGE PERSONAL INFORMATION CONCERNING ANY CLAIMS SUBMITTED WITH THE PLAN MEMBER OR A PERSON ACTING ON BEHALF OF THE PLAN MEMBER.

I UNDERSTAND THAT PERSONAL INFORMATION MAY BE SUBJECT TO DISCLOSURE TO THOSE AUTHORIZED UNDER APPLICABLE LAW.

IN THE EVENT MY CLAIM(S) ARE DECLINED BY THE INSURER/PLAN ADMINISTRATOR, I UNDERSTAND THAT I REMAIN RESPONSIBLE FOR PAYMENT TO THE PROVIDER FOR ANY SERVICES RENDERED AND/OR SUPPLIES PROVIDED.

☐ I have read and understood, and consent to the above
Initials: _____

Appointment Policy (Please read carefully)

WE EXERCISE A STRICT NO SHOW/CANCELLATION POLICY FOR ALL OUR PATIENTS IN ORDER TO DECREASE WAITING TIMES AND AS A COURTESY TO YOUR FELLOW PATIENTS.

- IF YOU NEED TO CANCEL OR RESCHEDULE YOUR APPOINTMENT, PLEASE CALL, TEXT, OR EMAIL US WITH A MINIMUM OF 24 HOURS NOTICE.
- IF YOU ARE UNABLE TO REACH US DIRECTLY, LEAVING A VOICEMAIL, TEXT, OR EMAIL 24 HOURS PRIOR IS ACCEPTABLE.
- IF YOU CANCEL OR RESCHEDULE YOUR APPOINTMENT WITHOUT 24 HOURS NOTICE OR MISS YOUR APPOINTMENT COMPLETELY, YOU WILL INCUR A FEE UP TO THE FULL COST OF YOUR APPOINTMENT.

☐ I have read and understood, and consent to the above
Initials: _____

Signature: