



CONSENT FORM

Consent for assessment & treatment		
Initial here	<p>Our healthcare practitioners are trained professionals and licensed by regulatory bodies for their specific profession to provide diagnosis and treatment for health-related concerns. Diagnosis, assessment and treatment may include physical examination and observation. If you are receiving any rehabilitation services and products, your treatment may include Physiotherapy assessment and treatment, massage therapy assessment and treatment, or others, as required. By initially and signing this form, you agree to treatment. All treatment, benefits and consequences, risk factors and alternatives can be explained, as needed. Consent can be withdrawn at any time.</p>	
Consent for cost of services		
Initial here	<p>A current fee schedule is provided in the clinic and online at the time you sign this Consent Form. You agree to:</p> <ul style="list-style-type: none"> • Pay for all services when they are provided • Pay for any uninsured services (services not typically covered: forms, letters, telephone calls) • Pay any outstanding balances if WSIB, EHC or MVA insurance companies do not cover the cost of your treatment • If you do not pay for a service at the time it is received, to pay interest on any outstanding balance at the rate of 2% per month and, on default, to pay all costs of recovering the debt, including legal and/or agent costs • To provide 24 hours notice when canceling an appointment. Because your appointment time is reserved exclusively for you and our professionals cannot use this time to see other patients, if you do not provide 24 hours notice of cancellation, you agree to pay our standard fee for the missed appointment. 	
Consent for personal information		
Initial here	<p>Headwaters Physiotherapy will collect some personal information about you in order to provide rehabilitation services. By initially and signing this form, you agree that:</p> <ul style="list-style-type: none"> • Headwaters Physiotherapy may collect, use, and disclose personal information about you, as set out in this form and the Headwaters Physiotherapy privacy policy • The Health Information Custodian is Headwaters Physiotherapy • You have had the opportunity to ask questions about how your information may be used • That the information will only be used in an appropriate manner, mainly for communication 	
Consent for release of imaging results		
Initial here	<p>Dr. _____</p> <p>Please forward any imaging results pertaining to the _____ to Headwaters Physiotherapy at: 8858-885-5306.</p> <p>Signature: _____</p>	
Name (print)	Signature	Date



All information you include is kept completely confidential. We take great care in storing your information securely.

CONTACT INFORMATION		
Last name	First name	Preferred Name
Today's date	Email (for appointment notification)	Date of birth
Home phone	Mobile phone	Work phone
Street address	City	Postal code
Emergency contact & relationship		Emergency contact phone
Why is it important you get this problem fixed now?		
What are two main things you would like to achieve at the end of today's consultation?		
How did you hear about us/who referred you?		
PHYSICIAN INFORMATION		
Family Doctor Name		Family Doctor Location
PAST/CURRENT MEDICAL HISTORY		
Current Medications		
Allergies		
Past surgeries		
Past illnesses/injuries		
Diagnostic testing (eg. XRay, MRI, ultrasound)		
Please read and initial		
Initial here	I understand that the information provided is accurate to the best of my knowledge. I understand that withholding important information will not allow my practitioner to treat me to the best of their ability.	