

Informed Consent for Physical Therapy

I, _____, hereby request and consent to the performance of physical therapy on me by the practitioner and individuals at St. Albert Physical Therapy & Sports Injury Clinic Inc.

I have had an opportunity to discuss with the office, therapist, and/or clinic personnel, the nature and purpose of the above mentioned therapy and other procedures. I understand that results are not guaranteed.

I further understand that, as in all health care, in the practice of the aforementioned therapy or exercise program that there are some risks to treatment and exercise, including, but not limited to, muscle strains and sprains. I do not expect the therapist, doctor, or clinic personnel to be able to anticipate all risks and complications to myself, and I wish to rely on the therapist, doctor, or clinic personnel to exercise judgment during the course of the procedures, which the therapist, doctor, or clinic personnel feels at the time, based upon the facts then known, is in my best interests.

I have read the above consent. I have had an opportunity to ask questions about its content, and by signing below I agree to the above-mentioned therapy or exercise program. I intend this consent form to cover my entire treatment.

Signature of Patient/Client _____ Date (dd/mm/yy): ___ / ___ /20 ___

Assignment of Payment

I hereby appoint the therapists from whom I receive treatments from St. Albert Physical Therapy & Sports Injury Clinic Inc. as my lawful attorney for the limited purposes of:

- Requesting and receiving benefits (as defined in the Health Professions Act) which benefits were provided to me by one or more therapists, and for which I, as "beneficiary" under the Act, am entitled to reimbursement pursuant to the act.
- Depositing any cheque issued in respect of such benefits, in any financial institution, to the credit of St. Albert Physical Therapy & Sports Injury Clinic Inc.

I acknowledge that if the cost of my treatment(s) is not met by the insuring company, e.g. Alberta Health Care, Community Rehabilitation Program, WCB or Third Party payments, I am responsible for any outstanding fee(s) including interest, for any assessments and treatments received.

The costs for such treatments are as follows:

MVA Initial Assessment:	\$243.00	MVA Treatment:	\$120.00
General Assessment (Physio/Acupuncture)	\$90.00	General Treatment/ per body part	\$65.00
Chiropractic Assessment:	\$60.00	Chiropractic Treatment	\$40.00
*Payment is due at time of treatment		*Interest on overdue accounts is 2.4% compounded monthly.	

Cancellation & No Show Policy: We require 24 hours notice for all cancellations. Failure to give 24 hours notice for non attendance will result in a fee of \$30.00 being charged to the patient/client.

Please sign below to confirm that you have read, understood and agreed to the above-mentioned information.

Signature of Patient/Client _____ Date (dd/mm/yy) ___ / ___ /20 ___

Signature of Witness _____

Email Address - _____

Consent for Release of Information

I consent to the release of obtaining of information about my condition to those involved in my care, including my insurance company, case worker, employer, lawyers, radiologist, and my physician.

Alberta Health Care: - _____ - _____ Date of Birth (dd/mm/yy) ___ / ___ / ___

Signature of Patient/Client _____ Date (dd/mm/yy) ___ / ___ /20 ___

Family Doctor: _____