BELMONT CENTRE FOR PHYSICAL MEDICINE

564 Belmont Ave. W., Suite 301, Kitchener, ON N2M 5N6 / Tel. (519) 743-4355 Fax (519) 743-6787

CONSENT FORM

Rev. September 2018

SOS Physiotherapy Kimberly Rau & Associates Inc.	Registered Massage Therapists KW Pelvic Health	

Patient Name: _____ Chart # _____

Welcome to the Belmont Centre for Physical Medicine. We want you to understand and consent to the services we provide to you, the costs involved, and what we do with personal information we obtain about you. Please read the following information and if you have any questions, please ask.

CONSENT FOR TREATMENT

Our health care practitioners are trained professionals licensed by regulatory bodies for their specific profession to provide treatment for health related concerns. Assessment and treatment may include physical examination and observation. If you are receiving rehabilitation services and products, your treatment may include: physiotherapy assessment and treatment; pedorthic assessment and treatment; massage therapy assessment and treatment; pelvic floor therapy assessment and treatment. The treatment services you undergo may be administered by the treating professional and by support staff under the supervision of the treating professional. By signing this form, you agree to our treatment.

CONSENT FOR THE COST OF OUR SERVICES

Our current Fee Schedule is posted in our front desk area. By signing this form, you agree:

- to pay for all services when they are provided
- 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 of payment, to pay all costs of recovering the debt, including legal and/or agent costs

Initial _____ (above section read)

CANCELLATION POLICY

By initialing the section below, you understand and agree to:

- to provide at least **24 hours** notice when cancelling 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 cancellation fee of **$65.00**. This fee also applies to **all** missed (no-show) appointments.
- PLEASE NOTE: Cancellation fees do not apply to appointments with Kimberly Rau & Associates Inc.

Initial _____ (above section read)

CONSENT TO COLLECT AND DISCLOSE PERSONAL INFORMATION

Belmont Centre for Physical Medicine will collect some personal information about you (including, without limitation, your name, age, contact information, health benefit information, occupational information, personal health information, medical history, etc.) in order to provide you with rehabilitation services and products. A copy of our Clinic Privacy Policy is available at our front desk which contains additional information about the collection, use, disclosure, retention and accuracy of personal information, steps taken to protect the information, and your right to review your personal information. Please ask the receptionist if you wish to read/review our Clinic Privacy Policy. By signing this form you agree that:

- Belmont Centre for Physical Medicine (BCPM) may collect, use, and disclose personal information about you as set out in this form and in BCPM's Clinic Privacy Policy
- you understand how our Clinic Privacy Policy applies to you
- you have had an opportunity to ask any questions you have about our Clinic Privacy Policy and they have been answered to your satisfaction
- you understand there are some rare exceptions to the commitments in our Clinic Privacy Policy, as explained in the Policies and Procedures for Personal Information issued by the Government of Canada
- we may exchange (release and receive) your medical records with your attending physician, insurance company, legal representatives, employer, the Workers Safety Insurance Board and any other Health Care Professional relevant to your care

I have read the Consent Form above and I agree to Belmont Centre for Physical Medicine (BCPM) collecting, using, and disclosing personal information about me as set out above and in BCPM's Clinic Privacy Policy.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Name (Print): _____ Relationship: _____