ASSURED HEALTH
PHYSIOTHERAPY

CONSENT FORM

By signing this form I, ____, understand the services which may include examinations and treatments are going to be provided for me by Assured Health. These services are required in order to physically assess me and if necessary improve my health, restore my function, and decrease my pain. I understand that one or more of the following services are going to be provided to me by this clinic in order to help me recover: Registered Massage Therapy ($95.00 for 60 Minutes), Swedish Massage Therapy ($80.00 for 60 Minutes), Physiotherapy ($70.00 for initial exam & per subsequent visit), Chiropractic ($70.00 for initial exam & per subsequent visit), and Cupping/Acupressure/Tuina ($90.00 for 60 Minutes & $60.00 for 30 Minutes) including any or all of the following: joint mobilization, joint manipulation, dispensing any products, soft tissue therapy, and interactive assessment. I might also be prescribed different medical equipment to facilitate my recovery, such as TENS machine ($300-$500), Lumbar brace ($325-$550), Knee brace ($190-$520/knee), Compression Stockings ($150-$250/Pair), Ankle brace ($140-$210/ankle), Shoulder brace ($270-$300/shoulder), Wrist brace ($125-$250/wrist), Elbow brace ($145-$260/elbow), Custom-made foot Orthotics ($400-$560/Pair), and Modified shoes ($245-$330/Pair). I am also aware that a 48 hour cancellation notice is required for appointments; otherwise there will be a $60.00 Cancellation fee.

I, _________________________________, understand that one or more of the above mentioned services will be performed on me in this clinic. What services I undergo here depend on my health needs, what I request, what my physician orders or what the health practitioner recommends. I understand the costs associated with services provided here and give my consent to be assessed, examined and treated here. There are risks and side effects associated with most medical treatments. Even though the chance is extremely low, there is the chance of neurological complications and stroke following neck manipulation and muscle soreness following chiropractic treatment. Physiotherapy carries risk of burning to body parts by physiotherapy modalities. Laser machine can damage eyes if exposed to eyes. Massage has been known to cause soreness in the muscles. I certify that I understand these risks and that I give my consent to be treated and examined at this clinic.

I understand certain custom made equipment cannot be exchanged for a different type or returned. I understand that my insurance will be charged for orthopaedic braces, foot Orthotics, and modified shoes once the product is received from the manufacturer no matter if I pick them up or not, as they are non-refundable. All other equipment/items can be exchanged or returned only within 5 days after pick up. Only returns and exchanges will be made if there are sizing, health, and serious personal issues of discomfort. Issues of personal distaste (colour, material, etc.) are not considered to be valid reasons for return or exchange. Any error found in the ordered item(s) that has been committed by third-party suppliers and not Assured Health are to be deemed as acceptable returns and exchanges. Items that have been extensively worn or opened for unnecessary reasons may not be exchanged or returned. If I have ordered duplicate items I may only open and use one at a time. Opening or using duplicate items may not be returned or exchanged. I acknowledge that Assured Health reserved the right to either accept or deny my claim for return and/or exchange.

I, ____________________________________, realize that my insurance company may pay my medical bills directly to me or my legal representative (if any). In this case, I will make sure this clinic receives payment through me or my legal representative no later than 7 days after payment is received. I also understand my insurance company may not pay fully for all the treatments and services I receive at Assured Health. In this case or the case that I might be out of benefit or that my insurance refuses payments for services rendered to me here, I accept to pay any outstanding balance. I realize that nothing free has been offered to me in this clinic.

I, ______________________________________, hereby authorize any agents, employees and or associates of Assured Health to complete forms on my behalf; speak on my behalf; release and/or request my clinical notes, reports and financial data or other information at their discretion to and from my insurer, my legal representative, my family physician or other health care practitioners or professionals involved in this claim. I also authorize Assured Health staff to discuss through phone, fax, e-mail, mail or any other communication media at their discretion any relevant information regarding services provided to me here to my extended health plan provider, my legal representative, my family physician and/or any other health care practitioners or professionals involved in this claim. I authorize my insurer and my family physician to release any requested information to this clinic and its agents and to communicate with them in regards to this claim on my behalf. In case of disagreement between myself and my extended health plan provider in regards to services provided to me in this clinic, I give authorization to this clinic or any of its associates to contact my insurer and its complaint centre on my behalf. If this fails to resolve the issue I give authorization to this clinic to represent me at Canadian Life and Health Insurance OmbudService and file a complaint against my extended health plan provider on my behalf. If the issue is not resolved, I give authorization to Assured Health Co. to act on my behalf and start any legal action necessary in order to resolve the issue. This may include retaining a lawyer or a paralegal on my behalf. This power of attorney shall expire in two years from the date signed below. By signing below, I acknowledge that I have read and understood the above and that all the above information have been explained to me and that I agree with all statements as such.

Patient Signature: ______________________________ Date: _________________________________