ASSURED HEALTH
PHYSIOTHERAPY

ICBC 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 ($109.00+GST for Initial visit- 60 Minutes, $82.00+GST per Subsequent Visits- 45 minutes), Physiotherapy ($256.00 for initial Assessment/Report, and $81.00 per Subsequent Visits- 30minutes), Active Rehab & Kinesiology ($138.00 for initial Assessment/Report, and $80.00 per Subsequent Visits- 60minutes), Chiropractic ($204.00 for initial Assessment/Report-45minutes & $54.00 per subsequent visit- 15minutes), And Acupuncture ($107.00 for Initial Assessment-60Minutes & $90.00 per subsequent visit-60minutes)

Changes to ICBC Part 7 Benefits after April 1, 2019

Health Care Service	Fee Limit For Assessment & Report	Fee Limit For Standard Treatment	Number of Pre-Approved Visits**
Chiropractic	$204.00	$54.00	25
Physiotherapy	$256.00	$81.00	25
Massage Therapy	$109.00	$82.00	12
Kinesiology	$138.00	$80.00	12
Acupuncture	$107.00	$90.00	12

***Within 12 weeks of the date of the accident causing the injury*

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 following neck manipulation and muscle soreness. It may carries risk of burning to body parts by physiotherapy modalities. I certify that I understand these risks and that I give my consent to be treated and examined at 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, ICBC, 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.

I _____ am also aware that a 24 hour cancellation notice is required for appointments; otherwise I will be responsible to pay $60.00 for any late cancellations. Also, I do understand that for any missed appointments or cancellation on the same day of treatment, I do require paying the session in full. ICBC will not pay for no-show or late cancellations appointments.

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: _____