SK Physiotherapy policies:

1. Please provide 24 hours' notice of cancellation for your appointment. A fee will be charged to your account if you do not show up for your appointment or if you choose to cancel within 24 hours of your appointment time.
2. Late arrivals will be seen for the remainder of their appointment time only. It is our goal to stay on schedule to the best of our abilities.
3. Payment is due in full at the end of each treatment session. Payments will be accepted by cash, debit, or credit card, and a receipt will be provided for reimbursement by your insurance company after each visit (If applicable).
4. If your visit is as a result of a motor vehicle accident, please provide all necessary information to our staff before your appointment. This includes your private insurance information (if applicable), adjuster contact information, and claim number.

Initial_____

Release of Medical Information:

Your privacy is of the utmost importance to us. The information collected in this intake form will assist us in treating you safely. All information provided will be kept confidential unless by the request of the patient to distribute, or required by law. Your written permission is required in order to release any of your treatment details, and for us to obtain information, from your previous/current health care providers. I authorize SK Physiotherapy to release my physiotherapy/massage therapy records to, and to obtain medical/health records from all practitioners concerned with my care.

Initial_____

Treatment Liability Waiver:

Doctors of Physiotherapists, Massage Therapists, and Chiropractic who use manual therapy techniques are required to advise patients that there are or may be some risks associated with such treatment. I understand and am informed that, as in the practice of medicine, there are some risks to treatment including, but not limited to the following some patients may experience short term aggravation of symptoms, rib fractures, muscle and ligament strains or sprains, bruising or disc herniation as a result of manual therapy techniques. While extremely rare, there are reported cases of stroke associated with many common neck movements including, chiropractic adjustment of the upper cervical spine. However, present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke Chiropractic treatment has been demonstrated to be an effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. The risk of injuries or complications from chiropractic treatment and/or manual therapy is substantially lower than that associated with many medical or other manual treatments, medications and procedures given for the same symptoms.

Initial _____

Exercise Liability Waiver:

I expressively acknowledge that I may be engaging in physical exercise while attending the clinic's facilities, which could cause me injury. I hereby state that I am and will be voluntarily participating in these activities and I hereby assume all risk of injury, which might result from these activities. I hereby waive and release any and all claims that I now have or may have against the clinic, its employees or agents for injury sustained by the clinic as a result of these physical exercises and activities. I hereby acknowledge that I have carefully read this waiver and release and thus fully understand that it is a release of liability of the clinic and I agree that such a waiver and release is reasonable and proper based on the nature of services provided by the clinic.

Initial _____

Consent to communicate via email or Phone:

To remind you of the time and date of your appointment, the scheduling software at SK Physiotherapy can automatically email you a reminder a day prior to your appointment or over the phone by the Patient coordinator. I authorize SK Physiotherapy to contact me via email or phone**.**

Initial _____

Consent for Medical Information:

I give permission for my therapists, insurance company, WSIB, employer, lawyer, or rehabilitation counselor to discuss any medical information pertinent to this claim or injury. By signing the consent section of this patient consent form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information as outlined above. I have reviewed the above information and understand how SK Physiotherapy will use my personal information and the steps SK Physiotherapy is taking to protect my information. I agree that SK Physiotherapy can collect, use and disclose personal information as set out above.

Initial_____

Informed Consent

I hereby give my consent to undergo therapy treatment. I have had the chance to discuss with my physicians, doctors and therapists the risks and benefits of treatment for my particular condition. Where appropriate, my treatment may include manual therapy, modalities (e.g. heat, ice, whirlpool, contrast bath, wax, laser, ultrasound, interferential current (IFC), electrical muscle stimulation, TENS, mechanical traction, acupuncture, dry needling, intramuscular stimulation), and active exercise. I understand that results are not guaranteed and that I may withdraw this consent at any time. If deemed appropriate by my therapist, I agree to have a student or support personnel carry out my treatment plan under supervision.

Initial_____

I have read, understand and agree to the clinic policy's set for by SK Physiotherapy. To the best of my knowledge, I certify that the information provided in the above forms are accurate and that I will advise SK Physiotherapy staff of any changes pertaining to my personal information and relevant health history. I consent to the treatment offered or recommended to me by my health care provider and I intend this consent to apply to all my present and future care.

_____ _____

Patient Signature or Parent/Legal guardian of Patient or Guardian Date(mm/dd/yyyy)