

INFORMED CONSENT (PART 2) MAPLE RIDGE PHYSIOTHERAPY AND PAIN CLINIC

Duty to Disclose Medical History:

I agree that I have a duty to fully disclose to the Therapist all medical conditions affecting me, whether or not I believe any medical condition is applicable or relevant to my treatment. I further agree that it is my responsibility to keep the therapist updated and informed of my medical condition. I declare that the information I have provided in the Medical History Form is true, accurate and complete.

Check here to indicate that you have read and agree to the above statement.

Release of Information (General):

I give my consent for the staff of Maple Ridge Physiotherapy and Pain clinic to obtain and/or release information from/to all treatment providers within this clinic, as well as physicians, lawyers, family members, third party insurance companies (e.g. Pacific Blue Cross), employers, hospitals or health care practitioners as deemed necessary for my continuing care. I also release the staff of the clinic from any and all claims directly associated with the release of this information.

Check here to indicate that you have read and agree to the above statement.

Release of Information (WorkSafeBC/ICBC):

I give my consent for the staff of Maple Ridge Physiotherapy and Pain clinic to obtain and/or release information from/to share all information related to the history, examination, assessment, and management of the injury related to WorkSafeBC / motor vehicle accident with ICBC as deemed necessary for my continuing care or the processing of my claim. I also release the staff of the clinic from any and all claims directly associated with the release of this information.

Check here to indicate that you have read and agree to the above statement.

File Retention:

I am aware that Maple Ridge Physiotherapy and Pain clinic must retain my Clinical Records for the duration of 16 years (as mandated by the Health Professions Act), either from the date of last entry or from the age of majority, whichever is later. If my therapist retires/leaves this clinic, these records may remain at this clinic for storage.

Check here to indicate that you have read and agree to the above statement.



Email/Phone/Texting Consent

I give permission for the clinic to contact me by phone and/or leave a message when required. I also consent receiving text messages on my cell phone with appointment reminders. By providing my email, I am consenting to email communication such as appointment reminders, invoices, exercise sheets, communication from my health practitioner & birthday wishes.

Check here to indicate that you have read and agree to the above statement.

Court appearance:

In a situation where the therapist is required to be present as either an expert witness or lay witness, I give my permission for Maple Ridge Physiotherapy and Pain Clinic to invoice costs as outlined by their respective professional association's (e.g. PABC) current fee guidelines in order to cancel their schedule to be present at the trial.

Check here to indicate that you have read and agree to the above statement.

Other notes:

A **no-show** fee of \$35 will be charged for physiotherapy or kinesiology appointments, or \$65 for massage therapy appointments if we are not notified of cancellations at least 24 hours in advance. We have voicemail that is available 24 hours a day, or you can also email us at <u>info@mapleridgephysio.com</u>

Due to extended insurance provider policies, any physiotherapy visits that involve acupuncture treatment can only be submitted as physiotherapy treatment, **not** acupuncture.

It is the patient's responsibility to keep track of all approval and end dates related to their claims. WorkSafeBC, ICBC, DVA, RCMP, and MSP accounts that are not honored by the insurer will be billed directly to the patient for payment.

User fees will no longer be recoverable from ICBC for claims with a date of loss on or after April 1, 2019. Patients however can submit receipts of user fees to their private health insurer (e.g. Pacific Blue Cross) for consideration of coverage.

I am aware of the above notes, and I am aware of the rates as indicated on mapleridgephysio.com

Patient Name

Date (YYYY/MMM/DD)

I agree that checking this box constitutes an electronic representation of my signature.