ACTIVE PHYSIOWORKS™
PHYSIOTHERAPY CLINICS

Informed Consent for Physical Therapy

I, _____, hereby request and consent to the performance of physical therapy on me by the practitioner and individuals at St. Albert Physical Therapy & Sports Injury Clinic Inc.

I will have the opportunity to discuss with the therapist and/or other office or clinic personnel, the nature and purpose of the above mentioned therapy and other procedures. I understand that results are not guaranteed.

I further understand that, as in all health care, in the practice of the aforementioned therapy or exercise program that there are some risks to treatment and exercise, including, but not limited to, muscle strains and sprains. I do not expect the therapist, doctor or clinic personnel to be able to anticipate and explain all risks and complications to myself, and I wish to rely on the therapist, doctor, or clinic personnel to exercise judgment during the course of the procedures, which the therapist, doctor, or clinic personnel feels at the time and based upon the facts then known, is in my best interests.

I have read the above consent. I will also have an opportunity to ask questions about its content, and by signing below I agree to the above-mentioned therapy procedures or exercise program. I intend this consent form to cover my entire course of treatment.

Signature of Patient/Guardian: _____

Date (mm/dd/yy): __ __ / __ __ / 20 __ __

Consent for Release of Information

I consent to the release of obtaining information about my condition to those involved in my care, including my insurance company, case worker, employer, lawyers, Alberta Health Services, WCB, radiologist, and my physician.

Alberta Health Care: __ __ __ __ __ - __ __ __ __

Date of Birth (mm/dd/yy): __ __ / __ __ / __ __

Signature of Patient/Guardian: _____

Date (mm/dd/yy): __ __ / __ __ / 20 __ __

ACTIVE PHYSIOWORKS™
PHYSIOTHERAPY CLINICS

Assignment of Payment

I, _____ hereby appoint the therapists from whom I receive treatment from St. Albert Physical Therapy & Sports Injury Clinic Inc. as my lawful attorney for the limited purposes of:

- Requesting and receiving benefits (as defined in the Health Professions Act) which benefits were provided to me by one or more therapists, and for which I, as "beneficiary" under the Act, am entitled to reimbursement pursuant to the act.
- Depositing any cheque issued in respect of such benefits, in any financial institution, to the credit St. Albert Physical therapy & Sports Injury Clinic Inc.

I acknowledge that if the cost of my treatment(s) is not met by the insuring company, e.g. Alberta Health Services, WCB or Third Party payments, I am responsible for any outstanding fee(s) including interest, for any assessments and treatments received.

The costs for such treatment(s) are as follows:

MVA Initial Assessment:	$260.00	MVA Treatment:	$150.00
Private Physio Assessment:	$105.00	Private Treatment/per body part:	$80.00
Acupuncture Assessment:	$105.00	Acupuncture Treatment:	$80.00
IMS Assessment:	$130.00	IMS Treatment:	$100.00

*Payment is due at time of treatment *Interest on overdue accounts is 2.4% compounded monthly.
In the event your account is referred to an outside collection agency, you will be responsible for any and all collection fees.

Cancellation & No Show Policy: We require 24 hours' notice for all cancellations. Failure to give 24 hours' notice for non- attendance will result in a fee of $40.00 being charged to the patient/client. _____Initial

Please sign below to confirm that you have read, understood and agreed to the above-mentioned information.

Family Physician: _____

Patient Phone Number: (__ __ __) __ __ __ - __ __ __ __

Home Address: _____

Email Address: _____

☐ I consent to be added to the monthly mailing list

Emergency Contact: _____

Emergency Contact Phone Number: (__ __ __) __ __ __ - __ __ __ __

Relation to Patient: _____

Signature of Patient/Guardian: _____

Signature of Witness: _____

Date (mm/dd/yy): __ __ / __ __ / 20 __ __