Freedom of Information and Protection of Privacy Act Information (FOIPOP)

All personal information collected is used for internal administrative and medical purposes only. If you have any questions or concerns about the clinic privacy policies, please contact the clinic manager (250-642-4911, sookephysio@shaw.ca) for further information.

Last Name	First Name	Initial(s)	Gender M F
Service #:	Rank:	Unit:	
Birthdate Year / Month / Day	Referring Physician:		
Mailing Address:			
City / Prov. / Postal Code	Day Phone	Evening Phone	
Email address:		Cell Phone:	

Please indicate the ways in which we can use your email address: ❑ All of the items listed OR:

❑ Appointment reminders ❑ Clinic Newsletter/Updates

❑ Invoices ❑ Personal letters and reports

So that we can better meet your needs, let us know if you have any of the following conditions:

❑ Environmental allergies Paralysis: ❑ paraplegic ❑ Other:

❑ Hard of hearing/deafness Paralysis: ❑ quadriplegic

❑ Latex allergy Paralysis: ❑ other

❑ Limited mobility (walker, cane or wheelchair) ❑ Poor vision/blindness

❑ Stroke

Canadian Forces Base (Blue Cross) CANNOT be billed for cancellation fees.

**** Any appointment missed without 24 hours notice is subject to a $50 cancellation fee.****

Consent for Treatment

It is the policy of the Sooke Evergreen Physiotherapy clinic to provide physical therapy treatments which are within the scope of physiotherapy practice as defined by the College of Physical Therapists of British Columbia (CPTBC). **Please ask for copy of the scope of practice if you would like more details.**

We wish to create an open and balanced patient-therapist relationship. This assists us in providing you with the best possible health care. Your rights as a patient include:

- Your therapist will answer the questions you may have about your condition and provide information about the treatment being used, including risks and benefits.
- You may discontinue or refuse treatment at any time during your appointment. Your therapist will respect your wishes, and will choose alternate methods of treatment at your request.
- If you choose to receive treatment from other health care professionals, please tell your therapist. This assists in planning your treatments here.
- To help us maintain confidentiality, ***please tell the receptionist if you are expecting someone to contact you*** at the clinic.

Based on the above conditions, I consent to physical therapy treatment provided by:

❑ John Manley ❑ Roger Norris

I also declare that all information on this form is accurate, ***and I will be responsible for any treatment cost***s, should my insurance carrier or funder fail to fulfill their financial agreement.

Signature of Patient _____ Date _____ Witness _____