

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

All personal information collected is used for internal administrative and medical purposes only. Your clinical records will not be released to any party without a signed release form. 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.

If you send your receipts to an insurance company for reimbursement, they sometimes require additional clarifying information about the dates of your treatments. Without your permission, we are not allowed to provide that information, so your receipts will be sent back to you.

Do you wish for us to provide or confirm treatment dates for your health insurer? Yes No

If you have a claim pending through ICBC or WCB, please inform the receptionist, who will provide different forms.

Last Name**	First Name**	Initial(s)**	Gender M F
**Please record your name exactly as written on your health card.			
Your Family physician:		Referral from: <input type="checkbox"/> your family physician <input type="checkbox"/> Other physician:	
Birthdate Year / Month / Day	CareCard Number: _ _ _ _ _		
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: <input type="checkbox"/> All of the items listed OR:			
<input type="checkbox"/> Appointment reminders		<input type="checkbox"/> Clinic Newsletter/Updates	
<input type="checkbox"/> Invoices		<input type="checkbox"/> Personal letters and reports	
So that we can better meet your needs, let us know if you have any of the following conditions:			
<input type="checkbox"/> Environmental allergies	Paralysis: <input type="checkbox"/> paraplegic	<input type="checkbox"/> Other:	
<input type="checkbox"/> Hard of hearing/deafness	Paralysis: <input type="checkbox"/> quadriplegic		
<input type="checkbox"/> Latex allergy	Paralysis: <input type="checkbox"/> other		
<input type="checkbox"/> Limited mobility (walker, cane or wheelchair)	<input type="checkbox"/> Poor vision/blindness		
	<input type="checkbox"/> Stroke		

Please read through this list of funders.

If your visit fees will be paid by one of these organizations, **circle the name and inform the receptionist, since additional information is required:**

Canadian Forces Base ✕ **Department of Veterans Affairs # K** _____

Premium-assisted MSP ✕ **Royal Canadian Mounted Police #** _____

Unit: _____ Collator: _____

****Any appointment missed without 24 hrs notice will be subject to a \$50 fee.****

Physiotherapy Visit Costs

Each assessment and/or treatment	\$57	
With MSP subsidy	\$22	Maximum (combined*) 10 visits/year
CFB, DVA, RCMP	n/a	Pre-approval required from funder

Massage Therapy Visit Costs

Per Hour	\$65	plus GST
With MSP subsidy	\$42	Maximum (combined*) 10 visits/year
CFB, DVA, RCMP	n/a	Pre-approval required from funder

i.e. maximum of ten visits/year for **physiotherapy, chiropractic, massage, podiatry, naturopathy and acupuncture.*

Chart #

Consent for Physiotherapy and/or Massage Therapy 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); and to provide massage therapy treatment within the scope of the BC College of Massage Therapy. **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

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

Dena McDonald

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

Signature of Patient

Date

Witness

OR

Signature of Parent/Guardian

Print name of parent/guardian if applicable:

If contact information for parent/guardian is different from that given for the patient, please indicate the changes here:

We appreciate hearing from you about your experience at the clinic, especially if you were not pleased with something. And we value your telling others when your experience was positive!

If you were not referred by a physician, how did you hear about our clinic?

Welcome Wagon

Client who has been to the clinic:

Sooke Lion's phone book ad

Yellow pages

Other: