Information, consent and release of information for WCB and ICBC Clients

Last Name**	First Name**	Initial(s)**	Gender M F

Please record your name exactly as written on your health card.

Family physician: Referred by: ☐ Family physician ☐ Other physician:

Birthdate Birthdate Year / Month / Day	CareCard Number: _ _ _ _ _ _ _ _ _ _
Adjuster Name and Phone Number:	Claim Number:

Mailing Address

City	Prov.	Postal Code	Day Phone	Evening Phone

Email address:	Cel 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 ❑ Letters and reports

I, ____ agree as follows:
(name, please print)

I sustained an injury on (date): Year / Month / Day

1. My medical insurance coverage for physiotherapy is provided by: (check one)
   ❑Insurance Corporation of British Columbia ❑WorkSafe BC
2. I give permission to the health professionals at Sooke Evergreen Physiotherapy Clinic (the Clinic) to contact the insurer indicated above, and provide information regarding my assessment, treatment and progress.
3. I realize that I can discontinue the permission given in Item 2 at any time through a written authorization. However, I also realize that withdrawing this permission may affect my insurance coverage through the insurers (see 5 below for details).
4. I am aware that the health professionals at the Clinic may provide information to my physician(s) regarding my assessment, treatment and progress.
5. I understand that my claim may not be accepted by the insurer at the time that physiotherapy treatment is started. **Until such time as my claim is accepted for physiotherapy treatment, I agree to pay all costs for my treatment. When my claim is accepted, all fees over and above the clinic user fee will be reimbursed by the Clinic.**
6. If my claim is not accepted by the insurer, I authorize the Clinic to bill MSP for those services covered through MSP.
7. Please note that your claim will not be processed by your insurer, until your insurer has received all paperwork from yourself and (if applicable) your employer.

Any appointment missed without 24 hours notice will be subject to a $50 fee. WCB and ICBC do not pay missed appointment fees.

Visit Costs

ICBC, no premium assistance:	$32	
ICBC, with premium assistance:	$22	Maximum (*combined**) 10 visits/year
WCB	$0	Claim approval required.

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

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 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 with

❑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.

Signed in Sooke, B.C. this ______ day of ______________________, 2_________
date month year

_________________________________ _________________ ______________________
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: