



## Welcome to Maximum Physiotherapy!

We look forward to meeting you and treating you in our clinic.

### We promise to:

- Welcome you into a professional and caring environment
- Listen to your concerns and answer your questions
- Clearly state the cost of our services and the payment structure up front
- Be on time to the best of our ability
- Provide you with the level of privacy you feel comfortable with (curtains can be drawn around treatment areas)
- Not charge you for missed or cancelled appointments provided that one business day's notice is given; otherwise you will be charged \$30.

### We appreciate your commitment to:

- Arrive on time
- Follow treatment plan instructions given to you by your therapist
- Wear clothing that makes it easy to access the area being treated (elastic- waist pants, shorts, sleeveless shirt - depending on the area)
- Pay for your treatments at your last appointment each week (we accept Visa, Master Card, debit, cash and cheque, or **Easy Pay Way**-explanation below)
- Turn your cell phone off when you enter the clinic as we aim to provide a relaxing healing environment for everyone
- Let us know what you think of your experience at our clinic (what you like and don't like)
- Pass our name along to friends and family if you are happy with our services

### Our 'Easy Pay' Way

Leave your credit card information with us and we will process your payment at your last appointment of the week. Your receipt will be ready for you at the end of your appointment without any wait times. If your children are being dropped off for treatment, this will save you an extra trip to come to settle up their account! When you have been discharged from the clinic we will remove your credit card information from our system.



## Client Information Sheet

Name: \_\_\_\_\_

Phone Home: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Work: \_\_\_\_\_

City/Town: \_\_\_\_\_

Birthdate: DD/MM/YYYY \_\_\_\_\_

Postal Code: \_\_\_\_\_

Email: \_\_\_\_\_

I would like appointment reminders by e-mail

Family Physician: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Emergency Contact #: \_\_\_\_\_

### Patient Health Information:

Diabetes

Stroke

Pregnant

Pacemaker

Heart / Lung Disease

Malignancy

Recent surgery

Metal implants

Have you been a patient here before? Yes  / No

If yes, what were you treated for? \_\_\_\_\_

Current area of treatment: \_\_\_\_\_

Are you here as a result of a motor vehicle accident? Yes  / No

Are you here as a result of a work place injury? Yes  / No

Check off all the ways that you have heard about our clinic:

another person \_\_\_\_\_ (name)

doctor \_\_\_\_\_ (name)

newspaper(EB/Creemore Echo)

phone book

radio

arena sign / arena TV

Sue's car

sign outside Clinic

outdoor message board

website

email/newsletter

other \_\_\_\_\_

69A First Street, Collingwood, ON Phone: 705-444-3600

[www.maximumphysiotherapy.com](http://www.maximumphysiotherapy.com)



## **Client Consent Form**

We want your informed consent. This means that we want you to understand the services we hope to provide to you, the cost involved and what we do with personal information we obtain about you. If you have a question about any of this, please ask.

### **Consent for the Cost of our Services:**

I understand that I must pay for my treatment/products in full at the end of each week. If my treatment is not paid for by a health insurance plan, I am responsible for payment. It is my responsibility to find out about my insurance coverage. If I am setting up a claim with Workplace Safety and Insurance Board (WSIB), I must have approval for treatment before my assessment. While waiting for approval, I can choose to pay for treatment on my own, but payments will not be reimbursed under any circumstances.

I understand that I will be charged for:

- missing or cancelling an appointment without giving 1 full business day's notice
- cheques written which have non-sufficient funds
- interest and administrative charges on accounts that are overdue by 30 days

\*\* all of these additional fees must be paid before any further treatment will be provided.

### **Consent for Release of Medical Information:**

I authorize Maximum Physiotherapy Services to release my medical reports to my physician, insurance company, WSIB, workplace, and other practitioners as requested.

### **Consent for Personal Information:**

I understand that to provide me with treatment, Maximum Physiotherapy Services will collect some personal information about me. I have reviewed Maximum's Privacy Policy about the collection, use and disclosure of personal information, steps taken to protect the information and my right to review my personal information. I have been given a chance to ask any questions about the Privacy Policy and they have been answered to my satisfaction. I agree to Maximum Physiotherapy Services using and disclosing personal information about me as set out above and in Maximum's Privacy Policy.

### **Consent for Assessment:**

I consent to an assessment by the therapists of Maximum Physiotherapy Services.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_