



ACTIVE HEALTH CENTRE
5871 Highway 7 East, Suite 101
Markham, Ontario L3P 1A3
T: 905-294-0454
F: 905-294-0480

**PHYSIO THERAPY DEPARTMENT
CONSENT FORM**

CONSENT TO TREAT AND CONSENT TO COLLECT AND DISCLOSE INFORMATION:

In accordance with the Federal Government's Personal Information Protection and Electronic Documents Act (PIPEDA) effective January 1, 2004, Active Health Centre – Physiotherapy Department needs your informed consent to provide assessment and treatment services to you, and to collect and use your personal information. We want you to understand the services we provide, the cost involved and what we may do with your personal information obtained about you.

CONSENT TO TREATMENT:

I agree to participate in assessments and treatments given by the treating provider. I understand that it will involve my active participation in treatment and will comply with the provider's recommendation in order to enhance my recovery. I acknowledge that my provider has given me information that is pertinent to my treatment, including the possible risks and side effects of the proposed treatment. Alternative courses of treatment have been explained to me. I understand the consequence of having and not having treatment. I understand that the assessment and treatment services I undergo may be administered by the treating provider, and by the support staff under the supervision of the treating provider.

CONSENT FOR THE COST OF OUR SERVICES:

I agree that I have been informed of the costs of the assessment and the treatments/services provided to me. I understand Active Health Centre may under some circumstances bill these services to my insurance company, or third party responsible for payment, and that I am responsible for paying in full, the balance of any amounts not paid by the insurance company or other third party. I understand that if no insurance company or third party is responsible for payment of services provided to me, that I am responsible for paying the full amount of those services. I understand that Active Health Centre may request of me a credit card imprint as security for payment of services.

PLEASE TURN PAGE OVER



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CONSENT TO COLLECT AND DISCLOSE PERSONAL INFORMATION:

Active Health Centre is responsible for the under its control, had developed a Privacy Policy, and has appointed a Privacy Officer to ensure that it complies with this Privacy Policy and all applicable privacy information affecting Active Health Centre's use of your personal information. Personal information that Active Health Centre collects, retains, uses and discloses may include without limitation, your name, age, contact information, occupational information, personal health information, medical history, and other information deemed necessary to fulfill the following purposes:

1. To provide assessment and treatment services.
2. To comply with the requirements of professional regulatory bodies, including file audits.
3. To contact you about services you have received or services we're offering. This may include (without limitation); follow-up calls or appointment reminders, newsletters, notices of promotions and special events.
4. To invoice you directly for services provided, and to process payment for those services.
5. To provide Third Party Payers, Physicians and Legal Counsel with progress reports / assessment findings, resulting from services provided to you.
6. To market services provided by Active Health Centre and its associates.
7. To determine best clinical practises, and ensure quality of service by staff of Active Health Centre.
8. To store information on behalf of Service Providers or Third Party Payers.

I understand that Active Health Centre may use, share, disclose and retain my personal information, in order to fulfill the purposes noted above, or where otherwise permitted by law. I understand that Active Health Centre collects, uses and discloses only personal information required to fulfill those purposes. I understand that Active Health Centre shall not use my personal information for purposes other than those noted above without my consent.

I understand Active Health Centre strives to ensure that my personal information is as accurate as possible and that Active Health Centre has in place security safeguards desired to protect against loss, theft, or unauthorized access or disclosure of my personal information.

I understand that I may request Active Health Centre's Privacy Officer to allow me to review my personal information, and that I may contact the Privacy Officer to challenge Active Health Centre's compliance with its Privacy Policy and applicable Privacy legislation.

I have read and understand this consent form. I hereby give Active Health Centre permission and consent to maintain personal information already of file with Active Health Centre, pursuant to its Privacy Policy, and to assign Active Health Centre and its agents, past, present, and future collections, uses, and disclosures of my personal information for the purposes set out in the Active Health Centre



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Privacy Policy. I understand that my consent may be revoked in writing as outlined in the Active Health Centre Privacy Policy.

I Consent for Treatment and Release of Information to and / or from the following:

Referring Physician: _____ (Speciality) _____

Family Physician: _____

I would like to have a discharge letter sent to the above physician(s) at the conclusion of physiotherapy treatment as required. (Please circle)

YES NO

Patient Name

Patients' Signature

__/__/__

Date

Witness Name

Witness' Signature

__/__/__

Date