HEALTH CONSENT FORM

Note to Client: We want your 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 any question on any of this, please ask.

CONSENT FOR ASSESSMENT AND TREATMENT

- I give my consent for the physiotherapy and/ or Acupuncture assessment and treatment proposed by the Physiotherapist at Helios Physiotherapy and Rehab Inc.
- I understand that the proposed treatment will consist of pain control, modalities, Acupuncture, Cupping, Education, Strengthening, use of weights and resistance, Cardiovascular exercise, US, heat/ cold, Vestibular Rehab, Manual therapy techniques (including stretching and mobilization), Pelvic Health, various exercises and possibly other methods discussed.
- I am also aware of alternative courses of action for treatment. Before any of the procedures are performed my practitioner discussed my treatment options and only proceed if my consent is given. The health care professional respects your right to modify, refuse or terminate treatment, regardless of prior consent given.
- I understand the advantages and benefits of having treatment, and likely consequences of not having proposed treatment. I am informed that there may be potential risk and side effects to treatment which are not limited to short term aggravation of symptoms, muscle soreness, skin redness, fatigue, burns etc. I do not expect the therapist to be able to anticipate and explain all the possible risks and complications.
- I understand that the results are not guaranteed.
- I authorize the practitioner to send/receive any information regarding my condition to/from to other health care practitioners, insurance companies or lawyers involved in my case.
- Cancellation Policy

  Please notify us 24 hours in advance to cancel your scheduled appointment, as spaces for appointments are limited. A 100% charge of service fee will be applied for failure to cancel in time.
- Payment Policy

  Payment is expected at the time of service. If my treatment services are submitted to 3rd party payers like extended health insurance/WSIB/ MVA/ LTD, and the 3rd party denies to pay all or any of the full amount submitted, I am responsible for paying the outstanding.

I, …… (Print name) have read and understand the fee schedule, Cancellation Policy and Payment Policy for all services provided. I accept the risks and my rights to consent to treatment.

Signature:……..Date:……

Physiotherapist:……