Informed Consent – Mariposa Physiotherapy & Rehabilitation

mariposa
Physiotherapy & Rehabilitation
8 Westmount Drive South
Orillia, ON L3V 6C9
Tel: 705-327-0008
Fax: 705-327-0018
www.mariposaphysio.ca

*Please **initial** each statement and fill in the blanks to signify that you have read, understand, & had all your questions answered sufficiently, then sign the bottom & submit:*

_____ I agree that I am attending Mariposa Physiotherapy & Rehabilitation to receive a Physiotherapy assessment/ treatment. I understand that part or all the assessment/treatment may take place on a secure teleconference platform due to social distant restrictions, or other personal restrictions from attending the clinic such as distance or ability to travel. I understand that the Physiotherapist (PT) will conduct an individualized assessment which may include asking me questions and doing a in-person or virtual physical and movement exam of the external muscular, vascular and nervous system. The PT will explain their findings, discuss treatment goals and explain all aspects of care, and I am to ask questions for clarification purposes when needed. I understand I can stop assessment/treatment at any time and all aspects of physiotherapy care are optional for me.

_____ I understand that the clinic has a Privacy Policy in place. I can find and read this written policy in the clinic waiting area, or on the clinic website (www.mariposaphysio.ca). I understand the Privacy Policy from Mariposa Physiotherapy & Rehabilitation regarding the collection, use and disclosure of personal information, steps taken to protect my information, and my right to review my personal information. I understand how the Privacy Policy applies to me. I have been given a chance to ask any questions I have about the Privacy Policy, and they have been answered to my satisfaction (705-327-0008).

_____ I consent to the collection of my personal information (verbal or written) as requested by Mariposa Physiotherapy & Rehabilitation and understand that this information is primarily used to guide my assessment, treatment plan and follow-up care, amongst other things, as outlined by the clinic Privacy Policy.

_____ We require **24-hour minimum notice** to cancel or change an appointment. We do our best to accommodate your schedule and respect your time, and we trust this respect is mutual. If you need to cancel an appointment **with less than 24 hours notice** or fail to show for said appointment; for any other reason than an unforeseen illness/death in the family, there will be a **cancellation fee equal to the full fee for the appointment you are cancelling or did not attend.** This policy is in place to protect our patients, so that they get appointments when they need them and so that we can ensure good outcomes for everyone to get better and out of pain.

_____ I understand that the assessment fee is $90-120 dependent on the time frame booked and each follow-up visit is $65-$120 (based on the type of care required & time frame booked). I understand that I am responsible for the payment of any fee/surcharge at the time of each treatment by cash, cheque, debit, visa/mastercard.

_____ I consent to work with the administration team at the clinic, who are responsible for bookings, payments and use of 3rd party insurance, as well as the delivery of any information passed on by your therapist (i.e. education or exercise sheets clinic information).

_____ I consent to have email communication sent to me regarding treatment, exercise, announcements, promotions or appointment questions from the clinic or my treating physiotherapist. Industry standard privacy precautions are used, but I understand that the use of email may pose a risk to my confidentiality, and I accept these risks. **My email address for communication is:**

_____

_____ I consent to have Mariposa Physiotherapy & Rehabilitation send copies or give verbal reports of my Assessment, Treatment plan, Interim Reports, Discharge Plan, and Follow-up Reports as applicable to the following individuals/organizations, and I further consent to the disclosure and collection of such personal information to/from:

Name each provider, person, or institution you wish us to communicate with: i.e. Doctor, Surgeon, Alternate Therapist, WSIB, Employer, Lawyer, Insurance Co. Etc.

_____

In the event that I wish to withdraw my consent, I understand that it is my responsibility to inform Mariposa Physiotherapy & Rehabilitation in writing. Mariposa Physiotherapy & Rehabilitation will then inform me whether and how such withdrawal will affect the service being provided to me. I fully understand the above consent statements and am entering into them voluntarily; this is certified by me submitting this form with either my signature or my name twice typed* name below:

Patient name*: _____ **Patient Signature*:** _____

Guardian or Substitute Decision Maker Name: _____ **Signature**: _____

Phone number: _____ **Date:** _____

Emergency Contact Name: _____ **Phone Number:** _____ **Relationship:** _____

Please note that a photocopy of this consent form will have the same authority as the original. The original form is not to be removed from the client's file at Mariposa Physiotherapy & Rehabilitation. When submitting this form electronically with your personal information and typing your name twice represents your legal signed consent.