Vancouver Physiotherapy and Sports Clinic
Client Terms and Conditions

CONFIDENTIAL PATIENT INFORMATION: All information provided is kept private and confidential. The release of any personal information requires your written and signed consent. **Your privacy is important to us.** Please fill out **ALL** of the following information clearly. Please ensure your name is as it appears on your care card.

First Name: ______________________________ Last Name: ______________________________

Cell Phone: ______________________________ Home / Work Phone: ______________________________

E-mail:______________________________ BC Care Card #: ______________________________

Date of Birth: Y: __________ M: __________ D: __________ Gender: Female | Male | ______________

Address: ____

City: ______________________________ Postal Code: ______________________________

How would you like to receive appointment reminders? (Please circle preferences):

E-mail SMS Text Both None

Emergency Contact: ______________________________ Phone: ______________________________

Physician (Full Name): ______________________________ Phone: ______________________________

How did you hear about Vancouver Physiotherapy?

____*(It really helps us out)*_____

TYPE OF VISIT:

◻ **Private** ◻ **MSP Premium Assistance** (See Front Desk)

◻ **Student Care**:** Student ID #: ____________________ School: ______________________

***You must advise us on your visit if you are covered by Studentcare. We will not make adjustments for past visits.*

Are you currently, or do you plan on, pursuing a claim with ICBC or WSBC for your injuries? If Yes please select below:

◻ ICBC ◻ WSBC

ICBC / WSBC Claim #: ______________________________ Date of Injury: ______________________________

Adjuster / Case Manager Name: ______________________________ Phone **Number**: ______________________________

Have you had surgery for this injury? Yes / No If yes, Date of Surgery: ______________________________

Have you had treatment for your injury prior to attending Vancouver Physiotherapy? Y / N If yes, what have you had?

___ Physiotherapy ___ Massage Therapy ___ Chiropractor ___ Naturopath Other ______________________

Please list any Medications you presently take: ____

Known Allergies (including medications, foods, oils and lotions, latex, etc.):______________________________

Late Cancellations & Missed Appointments:

In consideration of other clients and your therapist, please allow at least **24 HOURS NOTICE** to change or cancel an appointment. You will be charged the **FULL PRIVATE FEE ($79 - $115)** for late cancellations or missed appointment. Thank you.

______________________________ ______________________ ______________________

Signature Date Witness

AUTHORIZATION FOR RELEASE OF PERSONAL INFORMATION

In this document "Vancouver Physiotherapy and Sports Clinic" refers to its directors, officers, agents, representatives, employees, volunteers, independent contractors, subcontractors, successors and assignors.

How We Share Information:
Communication is key to safe and effective care. We may need to communicate with your physician or other members of your healthcare team. We will also contact you regarding your appointments and clinic information.

By signing this agreement I give permission for Vancouver Physiotherapy and Sports Clinic to communicate with other healthcare providers, Vancouver Physiotherapy and Sports Clinic staff, and third parties involved in my care. I authorize Vancouver Physiotherapy and Sports Clinic to contact me about my appointments, promotions, and clinic updates. I understand that my personal information is confidential and that Vancouver Physiotherapy and Sports Clinic will take the utmost care to safeguard my privacy. (A full copy of our privacy policy is available upon request).

CONSENT TO TREATMENT AND USE OF FACILITIES

There are risks and benefits involved with all types of therapies. Where appropriate my treatment may include manual therapy (involving treatment of the bones, joints, all soft tissue, nerves and nervous system, and organs of the body), modalities such as heat, ice, laser, ultrasound, interferential current (IFC), electrical muscle stimulation, TENS, mechanical traction, acupuncture, intramuscular stimulation (IMS), and active exercise. The response to a specific treatment varies from person to person, and it may not always be possible to predict one's response to a certain therapeutic modality or procedure, or technique. We cannot guarantee precisely what one's reaction to treatment may be, nor can we guarantee that any treatment will help the condition one is seeking for assistance. There is also a risk that one's treatment may cause pain or injury, or may aggravate a previously existing condition. You have the right to ask your therapist what type of treatment he or she is planning based on your history, diagnosis, symptoms, and personal goals. You may also discuss with your therapist what the potential risks and benefits of a specific treatment may be. Some potential risks may include:

- Health: strains; sprains; pain; overexertion; dehydration; fatigue.
- Premises: falls; collisions with objects, equipment or other people.
- Use of Equipment: mechanical failure of the equipment; negligent design or manufacture of the equipment; failure to use or operate the equipment correctly or within my own ability.
- My conduct and conduct of other persons: may increase the risk of damage, loss or personal injury.

You may decline any portion of your treatment at any time. It is important that you maintain an open and honest dialogue with your therapist, so he or she can adjust your treatment as needed.

By signing, I have read, understand, and agree with the information above. I understand there are risks associated with any treatment and that they may not be foreseeable. I understand that results are not guaranteed and that I may withdraw this consent at any time.

I also understand that medical records pertaining to my treatment at Vancouver Physiotherapy and Sports Clinic Centre are property of the clinic. At any time I may request access to view my records with my treating therapist. Copies of clinical records will be subject to a fee determined by the clinic.

I choose to pursue treatment at Vancouver Physiotherapy and Sports Clinic and waive any potential claim or liability against Vancouver Physiotherapy and Sports Clinic that may result from my treatment, except in the case of gross negligence on the part of Vancouver Physiotherapy and Sports Clinic and/or its staff and/or its professionals.

☐ **I consent for Vancouver Physiotherapy and Sports Clinic to communicate with my family doctor.**

Please Print Name: ____________________ **Today's Date:** ____________________
YYYY/MM/DD

Signature of Patient: ____________________ **Client Date of Birth:** ____________________
(or Signature of Guardian if patient is underage)

Witness: ____________________