NORTH AJAX REHAB & SPORTS INJURY CLINIC

95 MAGILL DRIVE / AJAX, ONTARIO / L1T 3K7
Phone #: 905-428-8811 Fax #: 905-428-8830

PART 1: ALL CLIENTS MUST COMPLETE

Client Information:

Last Name: _____ Address: _____

First Name: _____ City: _____

Home Phone: (____) _____ Postal Code: _____

Cell Phone: (____) _____ Work Phone: (____)_____ext._____

Birth date: Month _____ Day _____ Year_____ Age: ____ years Gender: ☐ Female ☐ Male

In Case of Emergency call: Name: _____ _____

Phone:(____) _____ Relationship to Client: _____

If known, date of injury: _____

Where your worst pain is located? _____

Please indicate your pain level by placing an X on the line below.

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

1 2 3 4 5 6 7 8 9 10

No Pain **Extreme Pain**

Referring Physician: _____ Phone #:(____) _____

Family Physician: _____ Phone #:(____) _____

Referral Source: ☐ Family Physician ☐ Specialist/Surgeon ☐ Dentist ☐ Family/Friends ☐ Yellow Pages ☐ Walk-in Clinic ☐ Other:_____

********** **Payment is to be made after each visit** **********

We accept: CASH, CHEQUE, VISA, MASTERCARD & INTERACT

It is your responsibility to send to your Extended Health Insurance Company for reimbursement

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PART 2: PLEASE COMPLETE IF YOU HAD A **WORK RELATED** INJURY OR ACCIDENT

WSIB Information:

Claim #: _____ Contact Person: _____

Employer: _____ Work Phone #: (_____) _____

Work Address: _____City: _____Postal Code: _____

Company Size: ☐ Small (19 or less) ☐ Large (20 or more)

Adjudicator's Name: _____

Adjudicator's Phone #: (____) _____

NORTH AJAX REHAB & SPORTS INJURY CLINIC
95 Magill Drive, Ajax, Ontario, L1T 3H4
(905) 428 - 8811

Health 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 on any of this, please ask.

Your consent is required for sections A/, B/, C/ :

A/ Consent for Treatment: ☐ PLEASE Initial your consent here

- Diagnosis, treatment and/or referral to other health care professionals are based upon the analysis of my condition revealed through personal history, interview and physical assessment.
- My Service Provider will inform me of, and I should understand the therapeutic treatment regarding expected benefits, potential risks and side effects, the likely consequences of not having/following the procedure(s) and what alternative course(s) of action are available.
- I am accepting or rejecting this care of my own free will and choice. I understand that I am ultimately responsible for my own health.

B/ Consent for Personal Information: ☐ PLEASE Initial your consent here

- You consent to release and/or obtain any personal information relating to your medical condition/treatment/or evaluation obtained or needed by your therapist as a result of or for the purpose of providing rehabilitation services.
- I understand that to provide me with Physiotherapy and Massage Therapy. North Ajax Rehab and Sports Injury Clinic will collect some personal information about me (e.g., home telephone number, address).
- Personal information can be used or disclosed to a legal authority with my signed consent
- If I have any questions regarding the Privacy Policy or my treatment program, I will be given a chance to clarify these issues with my Service Provider / Administration / Director.

C/ Consent for the Cost of our Services: ☐ PLEASE Initial your consent here

- **I ACCEPT FULL RESPONSIBILILTY FOR ALL / ANY FEES INCURRED DURING ASSESSEMNT AND TREATMENT** and agree that payment is due the day of the initial assessment and when services are rendered thereafter. Your insurance company is not responsible for payment of missed appointments and/or administration fees.
- **MISSED APPOINTMENTS**: Without prior 24 hours notification you will billed personally accordingly:
  - Missed physiotherapy appointments: $60.00 charge
  - Missed massage therapy appointments are billed according to your booking.

  I understand that there are some exceptions to these commitments.
- **IN THE EVENT OF NON-PAYMENT**: there will be an **ADMINISTRATION FEE of $50.00** added to your account and your account will be sent to an agency for collection of payment. Daily interest charges of 1.5% per month or 18% per year will be charged to outstanding accounts

Guardian's Name (Printed): _____
Guardian's Signature: _____
Relationship to Guardian if patient is a minor: _____

Date Signed: _____