COCHRANE PHYSIOTHERAPY CLINIC

REGISTRATION

Please Print

NAME:____
FIRST INITIAL LAST

ADDRESS:____

____
CITY PROVINCE POSTAL CODE

EMPLOYER:______________________________ **OCCUPATION**:______________________________

HOME TELEPHONE: ______________________________ **WORK TELEPHONE**:______________________________

CELL: ______________________________ **EMAIL**:______________________________

DATE OF BIRTH:______________________ **AGE**:__________ **MALE / FEMALE (Please Circle)**
MONTH / DAY / YEAR

EMERGENCY CONTACT NAME AND NUMBER:____
NAME NUMBER RELATIONSHIP

ALBERTA HEALTH CARE #:(WCB and AHS patients)____

Have you ever received Physical Therapy from this clinic? Yes / No If yes, when?______________________
Do you have a Family Physician? Yes / No If yes, who?______________________
Did a Physician refer you for Physical Therapy? Yes / No If yes, who?______________________

Is your injury/problem as a result of one of the following? (tick appropriate line)
Sport: _________ Non sport: (Orthopaedic, surgery, fracture):_____ MVA: ___________ WCB: _____________

Please indicate with an "x" any of the following that apply to your health:

Heart Disease______ Diabetes______ Pacemaker_____ Osteoporosis______
Metal Implant_____ Hepatitis A/B/C _____ Cancer_____ HIV/Aids_____
Anticoagulants_____ IUD_____ Epilepsy_____ Circulatory Disorders_____
High Blood pressure_____ Breathing Disorders_____ Arthritis RA / OA____ Pregnancy_____
Drug Allergies_____ Other____

As of September 1st 2008, AHS funding is available to patients meeting any of the following criteria:

1. Post fracture within 12 weeks of injury (1 initial visit + 6 further treatments)
2. Post operation (exclusions may apply) within 12 weeks of surgery (1 initial visit + 6 further treatments)
3. Have certain musculoskeletal or soft tissue conditions (formerly low income). To qualify, proof must be provided before the initial visit. (1 initial visit + 4 further treatments)

Patients wishing to apply for low income status must do so here. Funding under this program is limited and only available to those who have a valid Alberta Health Care Number. If you were involved in a motor vehicle accident or are claiming WCB, you are exempt from this funding. We encourage you to enquire about possible coverage for physiotherapy through other insurance: i.e. extended/private health care, school or athletic insurance.
Please note we can direct bill Blue Cross.

PAYMENT IS DUE AT THE TIME OF THE APPOINTMENT. A **$40.00** fee may be charged for failing to attend your appointment or cancelling without **24 hours notice**. If you are 10 minutes or more late, your appointment may be cancelled and be subject to the no show/cancellation fee.

PLEASE RESPECT YOUR SCHEDULED APPOINTMENT TIME.

REGISTRATION

Please Print

We ask that you sign below in acknowledgement and understanding of your liability of any costs incurred by you at this clinic:

SIGNATURE:____ DATE: _____________________________

(If under 18 years of age, this must be signed by parent / guardian)

Witness: ____ DATE: _____________________________

CONSENT TO RELEASE INFORMATION:

I hereby authorise this clinic to release information to my physician, insurance company, employer, WCB and/or lawyer:

SIGNATURE:____ DATE: _____________________________

(If under 18 years of age, this must be signed by parent / guardian)

Witness: ____ DATE: _____________________________

How did you find out about our clinic?

_____ Physician
_____ Other health care professional (please specify)______________________________________
_____ Yellow pages
_____ Advertisement (please specify)____
_____ Coach/Team (please specify)____
_____ Family/Friend
_____ Employer (please specify)____
_____ Lawyer (please specify)____
_____ Insurance Company (please specify)____
_____ WCB case manager (please specify)____

INFORMED CONSENT TO PHYSICAL THERAPY TREATMENT

I hereby request and consent to the performance of physical assessment and treatment on me by the Physical Therapists.
I have had the opportunity to discuss with the Physical Therapist the nature and purpose of the physical therapy treatment and other procedures. I understand that results are not guaranteed. I further understand and am informed that, as in all health care, in the practice of physical therapy there are some risks to treatment, including, but not limited to: muscles strains/sprains, disc injuries and strokes. I do not expect the Physical Therapist to be able to anticipate and explain all risks and complications and I wish to rely on the Physical Therapist to exercise judgement during the course of the procedures which the Physical Therapist feels at the time, based upon the facts then known, are in my best interest.
I have read the above consent. I have had the opportunity to ask questions about its content, and by signing below I agree to the above mentioned Physical Therapist procedures.
I intend this consent form to cover my current and future treatments. I understand that I have the right to withdraw my consent at any time.

Patient's Name: ___________________________ **Patient's (or Parent/Guardian) Signature**:___________________

Date:____________________