Welcome to Ace Physiotherapy

Welcome to Ace Physio. Ace Physio would like to extend a warm welcome and thank you for your confidence in trusting Ace Physio to assist you in restoring pain free function.

We believe in a client centered, holistic approach to managing sports and orthopaedic related injuries in addition to injuries from aging and illness. At Ace Physio we use our knowledge and expertise to treat your symptoms as well as provide a complete assessment to determine and correct the underlying factors that may have caused your injury/condition. We specialize in hard-to-treat conditions and a multi-disciplinary approach, by combining traditional evidence-based physiotherapy, with the most updated health care technology currently available. The goal is to treat pain and restore function and mobility in order to maximize your quality of life and assist you in achieving your optimum health.

Thank you for entrusting us to look after your health and well-being. We do not take this responsibility lightly, and we promise to do our utmost to ensure that your treatment goals are met and exceeded.

Sincerely,

Ace Physiotherapy and Allied Health Services

AcePhysio

CLINIC REGISTRATION FORM

Last Name: _____ **First Name:** _____

Age: _____ **Date of Birth (mm/dd/yy):** _____ **Gender/Sex:** _____

Address: _____ **Apt/Box #:** _____

City, Province: _____ **Postal Code:** _____

Home Phone #: _____ **Work Phone #:** _____

Cell Phone #: _____ **Email Address:** _____

Emergency Contact (name): _____ **Phone:** _____

How did you hear about us?

- ☐ Referral from Family Doctor (name) _____
- ☐ Referral from Trainer, Coach, Oher Therapist (name) _____
- ☐ Return Patient
- ☐ Yellow Pages
- ☐ Word of mouth
- ☐ Google
- ☐ Friend / Family member Advertisement
- ☐ Yelp
- ☐ Other _____

Survey: At Ace Physio, your comments and your health care are important to us. May we use your email to send you our Clinic Satisfaction Survey?

☐ Yes ☐ No thanks

Newsletter: On a quarterly basis, we send out an electronic newsletter that provides updates regarding our clinic, our services as well as advice and tips on health and injury prevention. Would you like to receive a copy of our newsletter via email?

☐ Yes ☐ No thanks

AcePhysio

CONFIDENTIAL MEDICAL SCREENING QUESTIONNAIRE

Name: _____ Date of Birth (mm/dd/yy): _____

1. Do you presently or have you ever suffered from any of the following? (Check all that apply)

- ☐ Heart problems
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Stroke
- ☐ Lung problems
- ☐ Cancer
- ☐ Diabetes
- ☐ Osteoporosis
- ☐ Broken bones / fractures
- ☐ Allergies:_____
- ☐ Arthritis
- ☐ HIV/AIDS
- ☐ Kidney problems
- ☐ Repeated infections
- ☐ Thyroid problems
- ☐ Skin disease / sensitivity
- ☐ Depression
- ☐ Asthma
- ☐ Epilepsy / Seizures
- ☐ Hepatitis

2. Have you had any surgeries or major dental work? (Please list)

_____

3. Please provide a list of your current medications:

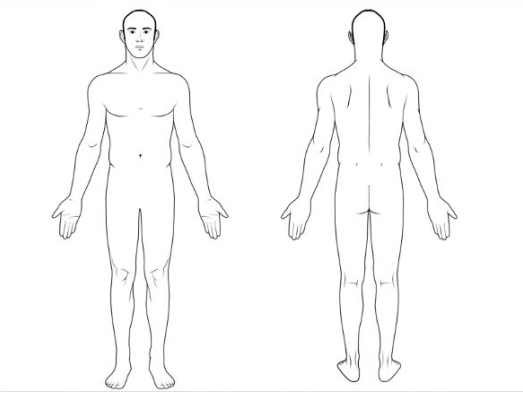
_____

4. Do you smoke? ☐ Yes ☐ No

5. Do you have a pacemaker? ☐ Yes ☐ No

6. FOR WOMEN: Are you currently pregnant or think you may be pregnant? ☐ Yes ☐ No

Please indicate your areas of pain



Please sign to indicate that you have answered all of the above to the best of your knowledge. Knowingly omitting information may put your health at risk.

Signature: _____ Date (mm/ dd/yy): _____

Thank you for completing this questionnaire. Your information is kept private and confidential. Patients will have a screening physical prior to their physiotherapy assessment.

AcePhysio

Consent to Physiotherapy Assessment

I hereby request and consent to the performance of physical assessment on me by the Registered Physiotherapist. I understand that I may ask questions at any time regarding:

- What the Physiotherapy Assessment is
- Who will be performing the Physiotherapy Assessment
- The reasons why I should have the Physiotherapy Assessment
- The alternatives to having the Physiotherapy Assessment
- What might happen if I do not have the Physiotherapy Assessment
- What potential risks and/or side effects exist for the proposed Physiotherapy Assessment

I understand that there may be risks if I do not disclose my full health history

My consent is voluntary and I intend this consent form to cover the entire course of assessment for my present condition, commencing on the date indicated below.

_____ _____

Patient's Name (print) Signature of Patient/Parent/Guardian

_____ _____

Witness Name (print) Signature of Witness

_____

Date

AcePhysio

Consent to Physiotherapy Treatment

I understand that there may be risks if I do not disclose my full health history.

I understand that my therapist will discuss treatment options with me prior to delivery of my care.

I understand that my treatment plan may include education, therapy, modalities and active exercise.

I understand that my therapist may incorporate a product (i.e. knee brace, orthotics, exercise bands) to accelerate my recovery. Your therapist may have a financial interest on certain products. However, you may choose to purchase this product elsewhere.

I understand that my therapist will educate me on the acceptable pain levels, expectations and management during my care/recovery.

I understand that the therapist develops, monitors and alters my treatment as indicated and that he/she will communicate with my affiliated physicians/specialists or other parties as needed.

I appreciate that while rare, fractures, strains, sprains or burns may result from my treatment.

I understand the consequences of not complying with the prescribed treatment may include no change in my signs or symptoms, delayed recovery and/or not achieving my goals.

I have had the opportunity to discuss the benefits and risks of treatment for my current situation.

I acknowledge I have discussed, or have had the opportunity to discuss, with my physiotherapist the nature and purpose of physiotherapy treatment in general and my treatment as well as the contents of this consent.

I understand that I may ask questions at any time regarding the contents of this consent form.

I consent to the physiotherapy treatments offered or recommended to me by my physiotherapist. I intend this consent to apply to all my present and future physiotherapy care. My consent is voluntary and I intend this consent form to cover the entire course of treatment for my present condition, commencing on the date indicated below. I understand that I may withdraw my consent at any time in writing except for actions already taken.

_____ _____

Patient's Name (print) Signature of Patient/Parent/Guardian

_____ _____

Witness Name (print) Signature of Witness

_____

Date

AcePhysio

PAYMENT AGREEMENT

+ **Fee Schedule**

Physiotherapy Initial Assessment with treatment 60 minutes* $99
Physiotherapy 30 minute Follow-Up $75
Physiotherapy 45 minute Follow-Up $100
Physiotherapy 60 minute Follow-Up $125
Virtual Physiotherapy 45 minute Initial Assessment with treatment $75
Virtual Physiotherapy 20 minute Follow-Up treatment $50
Physiotherapy Reassessment with treatment (45 minutes) $100
Spinal Decompression Treatment (45 minutes) $125
Spinal Decompression Assessment (60 minutes) $125

*An assessment is required for all first-time visits to an Ace Physiotherapist or for returning patients presenting with a new injury. If it has been longer than 6 months since your last visit, your therapist may require you to book an assessment appointment.

+ **Payment**

Payment is required after each visit. For your convenience we accept cash, cheques, Debit, Visa, Mastercard and American Express. We have the ability to directly bill some insurer carriers.

+ **Cancellation**

Please note that we require **24 hours notice** for cancellation of all appointments, otherwise you may be responsible for the full cost of that appointment. Patients who miss their appointment will be charged for their appointment.

I, _____ acknowledge that I have read and understood all of the terms of this payment agreement. I hereby confirm that I accept and agree to be bound by these terms.

+ **Signature** _____ Date: _____

AcePhysio

PRIVACY STATEMENT

I understand that to provide me with Physiotherapy goods and services, Ace Physio will collect some personal information about me (e.g., telephone number, address). Privacy of personal information is an important principle at Ace Physiotherapy. We are committed to collecting, using and disclosing personal information responsibly and only to the extent necessary for the goods and services we provide in accordance with the Personal Health Information Protection Act (PHIPA). We do not keep personal information for longer than is necessary, in order to protect your privacy. For more information you may ask our receptionist to view a copy of our Privacy Policy or contact Sharon Gabison, Ace Physiotherapy's Health Information Custodian.

I have reviewed Ace Physio's Privacy Policy about the collection, use and disclosure of personal information, steps taken to protect the 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 Policies and they have been answered to my satisfaction.

I understand that only if I check off the following boxes will I receive the following:

❑ I would like to receive notice when it is time to review whether I need new goods or services.

❑ I would like to receive newsletters and other informational mailings from Ace Physio

I understand that, as explained in the Policies and Procedures for Personal Information, there are some rare exceptions to these commitments.

I agree to Ace Physio collecting, using and disclosing personal information about me as set out above and in Ace Physio's Privacy Policy.

_____ _____

Patient's Name (print) Signature of Patient/Parent/Guardian

_____ _____

Witness Name (print) Signature of Witness

_____

Date