**Patient Information**

Name: Date of Birth:

Address:

City: Province: Postal Code:

Telephone (Res): (Cell): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email:

Would you like to receive appointment confirmations through Email: 🞏Yes 🞏No

**Family Doctor**

Name: Phone:

Address:

**Referring Doctor** (if different from Family Doctor)

Name: Phone:

Address:

**Please complete the following general health information**

 Yes No

Do you have cardiac problems? 🞏 🞏

Do you have a history of high blood pressure? 🞏 🞏

Do you have a pacemaker? 🞏 🞏

Are you a diabetic? 🞏 🞏

Are you pregnant? (if appropriate) 🞏 🞏

Do you have epilepsy? 🞏 🞏

Do you have a history of cancer? 🞏 🞏

Have you had any recent or major surgery? 🞏 🞏

Any other serious medical conditions which your physiotherapist should be aware of?

Are you currently receiving any other treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you find out about Brooklin Village Physiotherapy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact Information**

Name: Phone:

**Payment and Cancellation Policy**

Brooklin Village Physiotherapy is NOT covered through OHIP.

Payment will be due on the day of treatment and can be made by VISA, MasterCard, debit, cash or cheque.

We require 24 hours notice for canceling appointments. Insufficient notice or missed appointments (no shows) may result in a cancellation fee of $25.00 per instance, which is not covered by your insurance plan.

Please sign below to accept these conditions:

Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **DO YOU HAVE A QUESTION?**

If you have concerns about our competence or professionalism you can contact:

* Our Information Officer *Cheryl Davies*, can be reached in person or by phone at:
	1. *5959 Anderson St. Ste L3, Brooklin, ON L1M 2E9*
	2. *(905)655-7776*

If you wish to make a formal complaint, you may make it in writing. She will acknowledge receipt of your complaint; ensure that it is investigated promptly and provide you with a formal decision and reasons in writing

* College of Physiotherapists of Ontario: This policy is under the Personal *Information Protection and Electronic Documents Act*. There are some rare exceptions to the commitments set out above.
* For more general inquiries, the Privacy Commissioner of Canada oversees the administration of the privacy legislation in the private sector and deals with privacy disputes. The Privacy Commissioner can be reached at: *1(613)995-8210 or Toll Free: 1(800)282-1376*

**NOTE TO PATIENT**

 We want your informed consent. This means that we want you to understand the services we will provide you and what we do with personal information we obtain about you. If you have any questions on any of this, please ask.

**CONSENT FOR PERSONAL INFORMATION**

I understand that to provide me with rehabilitation services and products this clinic will collect some personal information about me (e.g. home telephone number, address, Health Number, Medication used and so on).

I have reviewed this clinic’s Privacy Policy with respect to 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 Policy and they have been answered to my satisfaction.

Please check if appropriate:

 I do not want to receive e-mails pertaining to my treatment (ie. exercises, education, enquiries about how I am doing, etc.)

 I do not want any reminders about outstanding bills or related information sent by e-mail

I understand that, as explained in the Privacy Policy, there are some rare exceptions to these commitments.

SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_