Total Balance
PHYSIOTHERAPY

We want your informed consent. This means that we want you to understand the services we provide, the costs involved, and what we do with personal information we obtain about you. Please address any questions/concerns regarding the below with your therapist.

I understand that my therapist, _____, will discuss what to expect from assessment and treatment options with me prior to delivery of my care. I understand that it is my right to be a decision maker when participating in the testing or treatment procedures and I may stop the therapist from performing any assessment or treatment that I do not feel comfortable with.

I understand there may be risks if I do not disclose my full health history, and that my therapist will educate me on the acceptable pain levels, expectations and management during my care and recovery. I understand that my progress will be monitored throughout my treatment. I understand that I am free to ask questions at any time.

I understand that to provide me with physiotherapy goods and services, Total Balance Physiotherapy will collect some personal information about me (i.e. address, home telephone number). I understand that Total Balance Physiotherapy has a Privacy Policy that gives detailed information 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 that my treatment plan may include education, manual therapy, modalities and active exercise. I understand that there is a very rare risk of strains, sprains or burns that can result from my treatment.

I understand that based on my response, my goals and my reassessment findings, that my treatment may be altered accordingly. I understand that I am obligated to inform the therapist of any symptoms (i.e. pain, discomfort, nausea) that I may have during all interaction with the therapist and other staff, including symptoms that may occur after I have left the therapists office during the time that I am an active patient.

I understand that the therapist may stop the testing/treatment procedure if they observe any signs of concern, or if they believe I have reached my safe limits/plateau. I understand that consequences of not complying with the prescribed treatment may include: no change in my signs/symptoms, delayed recovery, and/or not achieving my goals. I understand that my therapist may discontinue treatment due to non-compliance (examples of non-compliance: not being on time for appointments, not complying with the policies re: payment for PT services provided and any additional admin costs including those for missed appointments, and disrespectful behaviour towards any staff member of Total Balance Physiotherapy).

I understand there are many factors that play a role in achieving full recovery. It may be possible that I will not fully achieve my initial goals and that they will need to be adjusted along with my expectations of recovery. I appreciate that my therapist will review the typical recovery timelines with me, however, variances may occur from person to person.

I understand that support personnel (i.e. PT Aide) will assist my therapist in delivery of my care. I understand that support personnel are following the plan that has been developed and directed by my therapist. 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 understand that students may assist my therapist in the delivery of my care, that I will be notified of this at the time and that the students are under the physiotherapist's supervision.

I understand that my therapist may incorporate a product (i.e. brace, orthotic) to accelerate my recovery. Total Balance Physiotherapy may have a financial interest on certain products. However, I understand that I am not obligated to purchase and/or may choose to purchase the product elsewhere.

I understand that this consent will apply to my treatment going forward and that I may withdraw consent at any time.

Costs of Services I understand I can discuss any financial concerns with my therapist, regarding the overall cost and frequency of treatment.

Regular Assessment: $90	Vestibular/Concussion/Head Injury Assessment: $130
Follow up Visit: $55	Vestibular/Concussion/Head Injury Follow up Visit: $85
No Show/Late Cancellation (<24 hr notice): $25	Taping: $15
Orthotics: $365	Complex/Re-assessment/Extra time needed: $75
Massage (Gravenhurst location only):	60min $80, 45 min $65, 30 min $45 (plus HST)

I, _____, consent that the therapist may proceed with the assessment and treatment as they see fit. I also agree to Total Balance Physiotherapy collecting, using and disclosing personal information about me as set out above and in the Total Balance Physiotherapy's Privacy Policy.

SIGNATURE: _____ DATE:_____

PRINTED NAME: _____ DATE OF BIRTH:_____/_____/_____ (dd/mm/yy)