

**Welcome to A Body In Motion Rehabilitation!**  
*Please take a few moments to fill out all of the information below  
and to carefully read and sign the back of this form.*

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Postal Code: \_\_\_\_\_

Telephone Number: (Home): \_\_\_\_\_ (Cell): \_\_\_\_\_

(Work): \_\_\_\_\_

E-Mail Address (for email reminder): \_\_\_\_\_

Family Physician: Name: \_\_\_\_\_  Check if referred to our  
Address: \_\_\_\_\_ facility by your family  
Telephone: \_\_\_\_\_ physician

Who can we thank for referring you? \_\_\_\_\_

Date of Birth (month/day/year): \_\_\_\_\_

Date of Injury (month/day/year): \_\_\_\_\_

Health Card Number: \_\_\_\_\_

Current Medications (please list): \_\_\_\_\_

Have you ever experienced or are you currently experiencing any of the following:  
(please check only those that apply to you)

diabetes _____	high blood pressure _____
heart disease/heart attacks _____	epilepsy _____
kidney problems _____	cancer _____ type: _____
dizziness/vertigo _____	nervous disorders _____
pacemaker _____	migraines/chronic headaches _____
hernia _____	previous surgeries _____
allergies (please list) _____	
are you currently pregnant? _____	

Are there any other conditions that your family physician follows on a regular basis:

\_\_\_\_\_

Once again, we would like to welcome you to A Body In Motion Rehabilitation. We look very forward to treating you and we would like to thank-you for choosing us to help you heal!! Here are a few recommendations to help make you comfortable while you are with us:

- 1) Please dress appropriately. We ask that you wear comfortable clothing that will allow you to move freely. We suggest loose fitting clothing.
- 2) Ensure that your appointments are scheduled and that you receive written confirmation of these appointments. **If you arrive late for your scheduled appointment you will not receive the full 20 minutes of treatment time with the physiotherapist.**
- 3) If you must cancel a scheduled appointment, **24 hours notice is greatly appreciated.** If 24 hours notice is not provided, **you will be charged for the full price of the appointment.** Initial: \_\_\_\_\_

**\*FEES FOR SERVICE PROVIDED AND PAYMENT RESPONSIBILITY\***

A Body In Motion Rehabilitation is a privately owned and operated clinic. Unfortunately, we do not receive any form of OHIP funding. For this reason, **you, the client**, are responsible for payment for all services received. Fees for service are as follows:

<b>Initial Assessment</b>	<b>\$100.00</b>
<b>Subsequent Treatment</b>	<b>\$65.00</b>
<b>Doctor/Work Letters</b>	<b>\$20.00</b>

To ensure that you have understood the fees and payment schedule, please read the following:

I, \_\_\_\_\_, understand that I am responsible for the payment of all professional services that I receive at A Body In Motion Rehabilitation. It is my responsibility to pay my bills when they are presented to me and, it is my responsibility to submit my receipts for reimbursement from my extended health care provider. I understand that payment is due on the day of service unless otherwise stated by the owners and that overdue accounts may be forwarded to a collections agency where a 35% processing/interest fee will be added to the balance owing.  
Signature: \_\_\_\_\_

**The injury I am seeking treatment for is not a workplace injury. I have not and do not intend to initiate a claim with WSIB for this injury. I understand and accept that if I do open a claim in the future for this injury A Body In Motion Rehabilitation will not reimburse payments made.**

Signature: \_\_\_\_\_

**\*INFORMED CONSENT AND MEDICAL RELEASE\***

I hereby authorize the representative of A BODY IN MOTION REHABILITATION to obtain and review copies of any hospital, medical, or other related health records. I give permission for these same representatives, to discuss and to release valid, related health information to other health professionals, insurance representatives or employers whom may be involved in my rehabilitative care.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**\*TIME ALLOTTMENT FOR TREATMENT\***

Just a reminder that when you visit us for an initial assessment, we are able to thoroughly assess one body part in the allotted time. We want to provide you with the best possible care and compiling treatment will take away from your healing and increase the time frame required for your therapy.

Thanks so much for your understanding!

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Again, we would like to welcome you to our facility!! Any questions, please feel free to ask us!!*

# Patient Privacy Protection Form

*A Body In Motion Rehabilitation*  
*70 Victoria St N*  
*Kitchener ON N2H 5C2*

It is very important to us that we receive your **informed consent**. What this means is that we want to ensure that you understand the services that we provide to you, and what we do with the personal information that we obtain from you. We have an outlined “Privacy Policy” for A Body In Motion Rehabilitation, which is always available for your perusal. Please do not hesitate to ask for the policy manual if you would like a more detailed explanation than what is outlined in this form.

Important Information for you, the Client:

\*Like all physiotherapy clinics, we collect, use, and disclose, personal information in order to better serve you. The primary purpose for collecting information is to safely and effectively provide physiotherapy services. This information will always be collected with your consent and distributed with your consent. Distribution of information occurs only for billing purposes (WSIB or MVA clients), treatment purposes, and /or for professional review.

\*Your information will be securely kept for a minimum of 8 years and a maximum of 10 years. We are required by the Ontario College of Physiotherapists to maintain and retain our client’s records. The person responsible for maintaining your confidential information is our Health Information Custodian, Keri Martin Vrbanac.

\*We understand the importance of protecting personal information. For this reason, we have taken the following steps:

- Paper information is under supervision or in a restricted area at all times.
- Electronic hardware is under supervision or has restricted access at all times.
- Reputable companies transmit paper information through sealed, addressed envelopes.
- Electronic information is transmitted through direct lines, and marked as “personal and confidential”.
- Staff is trained to collect, use, and disclose personal information only as necessary to fulfill their duties in accordance with our privacy policies.
- External consultants and agencies with access to personal information (WSIB, insurance companies) must enter into privacy agreements with us.

\*We do not share personal information with any agencies not directly related to your physiotherapy treatment care and we do not provide our patient’s information to solicitors.

Consent for Personal Information:

I understand that to provide me with rehabilitation services and products, the clinic is required to collect personal information. I understand the collection, use, and disclosure of this personal information, and I have been offered a more detailed explanation through the Privacy Policy Outline for A Body In Motion Rehabilitation. I understand how the privacy policy applies to me and I have been given the chance to ask questions with respect to clarification.

I agree to A Body In Motion Rehabilitation collecting, using, and disclosing personal information about me as set out above and in the Privacy Policy.

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

*We wanted to let you know that we do our very best to have the same therapist follow you through your treatment. If your preferred schedule time is taken, and you do not feel comfortable working with one of our other therapists, please let us know and we will do our very best to accommodate you!!*

*We want you to know that we are 100% dedicated to the partnership that we have begun with you and it is our goal to work with you to obtain positive results!*