PHYSIOTHERAPY
ACTIVE REHAB

PATIENT CONSENT FORM
WSIB

I give my consent for treatment at *Physiotherapy Active Rehab*. I understand that treatment may change at the therapist's discretion, and I am aware of my right to withdraw my consent to treatment at any time.

I understand that all services provided by *Physiotherapy Active Rehab* are by appointment only. Cancellation can be made with no charge if a minimum of 24 hours notice is given. Failure to notify within this time will incur a fee of 50% of the treatment costs. Please be advised that this fee is not covered by your extended health carrier nor WSIB.

I hereby authorize *Physiotherapy Active Rehab* to obtain or release any required information pertaining to my health and rehabilitation. Information may be obtained or released to: Family Physician, Insurance Company, or Employer.

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PLEASE NOTE THAT YOUR WSIB CLAIM IS NOT DEEMED APPROVED UPON ARRIVAL OR BOOKING OF APPOINTMENT. THE CLAIM IS ONLY DEEMED APPROVED WHEN WSIB PERSONALLY CONTACTS OUR OFFICE

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a) ____ I _____ have extended heath coverage that can be

billed if my WSIB claim is denied or not paid in full

_____ _____ _____
Patient Name (please print) Patient Signature Date

OR

b) ____ I _____ do not have any extended health care

coverage that I am covered under. I fully understand as well as expressly agree that I will be personally responsible for the full costs of services from Physiotherapy Active Rehab if WSIB denies my claim

_____ _____ _____
Patient Name (please print) Patient Signature Date

3163 WINSTON CHURCHILL BLVD, UNIT D MISSISSAUGA ONT L5L2W1