



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.

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

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