OASIS
MISSION PHYSIOTHERAPY

**O**rthopaedic **A**nd **S**ports **I**njury **S**ervices

## PATIENT CONSENT FORM

Our clinic is committed to ensure you receive quality informed care and that your privacy is protected. For the duration of your treatment we request your informed consent to:

- Provide assessment and treatment services to you,
- Collect, use, and share any relevant clinical information in providing services to you.

CONSENT TO ASSESS and TREAT

Treatment Information: Physiotherapy treatment techniques recommended to you may include, but are not limited to: manual techniques, spinal manipulation, therapeutic exercise, electrotherapeutic modalities, as well as other techniques and procedures your treating physiotherapist determines may improve your function. Your physiotherapist will explain the benefits, side effects and potential complications of each chosen technique before use.

Throughout your recovery program, any questions or concerns you may have about any recommended treatment must be shared with your physiotherapist immediately so they can explain the treatment rationale and/ or modify your program appropriately. If at any time you choose not to participate in the course of treatment, please tell your physiotherapist immediately.

I, _____, hereby freely consent to participate in the physical and functional assessment and recommended treatment program (based on my medical history, diagnosis, symptoms and assessment results) delivered by those authorized in this clinic, having been informed about the following:

- What to expect in the assessment and treatment;
- Who will be performing the assessment and treatment;
- The reasons why I should have the assessment/treatment
- What might happen if I do not have the assessment/treatment; and
- Any potential risks and/or side effects for the assessment and recommended treatment.

I understand and agree with the criteria above and as such agree to participate in an assessment and treatment program. My consent is voluntary for the entire course of assessment and treatment for my present condition, commencing on the date indicated below. I understand that I may ask questions at any time, and that my consent may be withdrawn in writing at any time, except for actions already taken.

| **Consent to Assessment** | **Consent to Treatment** |
|---|---|
| _____ | _____ |
| Client Signature | Client Signature |
| _____ | _____ |
| Physiotherapist Signature & Designation | Physiotherapist Signature & Designation |
| _____ | _____ |
| Date | Date |

CONSENT to the RELEASE of INFORMATION

I _____ give my informed consent to the Clinic to release information with respect to my care to the following:

1. **Insurer:** To disclose medical and/or other information with the relevant third party (indicate ICBC, WSBC, extended health insurance, etc): _____
   ☐ Yes ☐ No _____ Initials

2. **Medical Professional**(s): To disclose medical information to and obtain medical information from my Physician, Specialists or other treating therapists for the purpose(s) of assessing or providing treatment services.
   _____ ☐ Yes ☐ No _____ Initials
   _____ ☐ Yes ☐ No _____ Initials
   _____ ☐ Yes ☐ No _____ Initials

3. **Employer or their Representative**: To discuss return to work information with my Employer or their Representative (per the limitations of this discussion as reviewed with my physiotherapist)
   _____ ☐ Yes ☐ No _____ Initials

4. **Lawyer**: to disclose medical or other information to my Lawyer (if applicable)
   _____ ☐ Yes ☐ No _____ Initials

5. **Other** (explain) _____
   ☐ Yes ☐ No _____ Initials

**I understand that my consent may be amended or revoked in whole or in part at any time by providing written notice to the Clinic as outlined in the clinic's Privacy Policy, and that revoking consent may have additional consequences such as withdrawal of treatment or the decline of a payment by an third party payer.**

| _____ | _____ | _____ |
|---|---|---|
| Client Name | Signature | Date |