ICBC PATIENT CONSENT FORM

Patient Name: _____ Patient DOB: _____

Claim Number: _____ Date of Accident: _____

ICBC Adjustor Name: _____ Phone Number: _____

Lawyer Name if applicable: _____ Phone Number: _____

I understand if Oasis Mission Physiotherapy cannot confirm coverage, I will pay the full fee for the visit or visits.
_____ Initials

I agree to give consent to Oasis Mission Physiotherapy to share all information related to the history, examination, assessment and management of the motor vehicle accident with ICBC. _____ Initials

"If practitioners receive this request from ICBC, they are obliged under section 28.1 of the Insurance Vehicle Act to provide the information requested in the report, to the extent that it is known by the health care provider. "

I agree to give consent to Oasis Mission Physiotherapy to disclose medical information to and obtain medical information from my physicians, specialists or other treating therapists noted below for the purpose of assessing or providing treatment services. _____ Initials

Doctor Name: _____

Doctor Name: _____

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. Revoking consent may have additional consequences such as withdrawal of treatment or the decline of payment by ICBC. _____ Initials

Patient/Guardian Signature:_____ Date:_____