Patient Consent to Treat and Consent to Collect and Disclose Personal Information

Pursuant to the Personal Information Protection and Electronic Documents Act ("PIPEDA"), effective January 1, 2004

We respect your privacy. PHYSIOTHERAPY ALLIANCE needs your informed consent to provide assessment and treatment services to you, and collect and use your personal information. We want you to understand the services we provide, the cost involved, and what we may do with your personal information. A copy of your Clinic Privacy Policy is available for viewing at our front desk.

CONSENT FOR TREATMENT

I agree to participate in assessments and treatments given by the treating provider. I understand that this will involve any active participation in treatment, and will comply with the provider's recommendation in order to enhance my recovery. I acknowledge that my provider will be providing me with information that is pertinent to my treatment, including the possible risks and side effects of the proposed treatment. Alternative courses of treatment as well as the consequences of having and not having treatment will be explained to me. I understand that the assessment and treatment services I undergo may be administered by the treating provider and by support staff under the supervision of the treating provider.

CONSENT TO COLLECT AND DISCLOSE PERSONAL INFORMATION

The clinic is responsible for the personal information under its control. A Privacy Policy has been developed, and a Privacy Compliance Team appointed to ensure compliance with this Privacy Policy, and all applicable privacy legislation affecting the clinic's use of your personal information. Personal information that the clinic collects, retains, uses, and discloses may include, without limitation, your name, age, contact information, health benefit information, occupational information, personal health information, medical history, and other information deemed necessary to fulfill the following purposes:

a) To provided assessment and treatment services.
b) To comply with the requirements of professional regulatory bodies, including file audits.
c) To contact you about services you have received or services we are offering. This may include (without limitation): follow-up calls or appointment reminders.
d) To invoice you directly for services provided, and to process your payment for those services.
e) To invoice Third Party Payers for services provided to you.
f) To provide Third Party Payers, Physicians and Legal Counsel with progress reports/assessment findings, resulting from services provided to you.
g) To determine the best clinical practices, and ensure quality of service by staff of the clinic.
h) To store information on behalf of Service Providers or Third Party Payers.

I understand that the clinic may use, share, disclose and retain my personal information, in order to fulfill the purposes noted above or where otherwise permitted by law. I understand that the clinic collects, uses, and discloses only personal information required to fulfill the purposes noted above, and reta any personal information only as long as necessary to fulfill those purposes. I understand that the clinic shall not use my personal information for purpos other than those noted above without my consent.

I understand that the clinic strives to ensure that my personal information is as accurate as possible and that the clinic has in place security safeguards designed to protect against loss, theft, or unauthorized access or disclosure of my personal information.

I understand that I may request of the clinic, a copy of its Privacy Policy. I am aware that I may direct any questions about my personal information or th clinic Privacy Policy to its Privacy Compliance Team.

I understand that I may request the clinic's Privacy Compliance Team allow me to review my personal information, and that I may contact the Privacy Compliance Team to challenge the clinic's compliance with its Privacy Policy and applicable Privacy Legislation.

I have read and understood this consent form. I hereby give the clinic permission and consent to maintain personal information already on file with the clinic, pursuant to its Privacy Policy, and assign to the clinic and its agents, past, present, and future collections, uses, and disclosures of my personal information for the purposes set out in the clinic Privacy Policy. I understand that my consent may be revoked in writing as outlined in the clinic privacy policy.

I hereby authorize release and/or collection of all information related to my attendance, the status of my injury(s), treatment received, progress or lack of progress, and any work environment, or family/social problems that appear to be impacting on my recovery, to my physician, insurance company, rehabilitation company, employer, or the Workplace Safety and Insurance Board. WSIB: I further authorize Physiotherapy Alliance to release all information related to my suitability to return to work, and any necessary work restrictions to my employer throughout my recovery.

_____	_____	_____
Patient Name	Signature	Date
_____	_____	_____
Witness	Signature	Date

CHART # _____