



TELEREHABILITATION CONSENT FORM

PATIENT INFORMATION

First Name	Last Name	Date of Birth (mmddyy) /
/		
Address	City	Province Postal Code
Gender Male Female	Telephone (H)	(M)
Email		
Unsubscribe button at the bottom page	on to our patients via our email newsletters e of the newsletter. Physiotherapy Clinic to email me their ne	·
How did you hear about us?		
Google, online ads, website	Social media	
Street sign	Referred by friend	nd or family:
Others:		
EMERGENCY CONTACT		
Full Name	Relationship	Telephone
CARE PROVIDER INFORMATION		
Family Doctor's Name		Telephone
Referring Doctor's Name		Telephone

METHOD OF PAYMENT (Please read completely)

Please select a method of payment:

MAPLECARE
PHYSIOTHERAPY &
 NEURO REHAB CENTRE
Credit Card
E-Transfer
Private Insurance
Other:

1173 Wellington St. West, Ottawa, ON K1Y 2Y9 - (613) 695-1111 203-1637 Woodroffe Ave., Nepean, ON K2G 1W2 - (613) 691-1515 1395 Bank Street, Ottawa, ON K1H 8N1 - (613) 627-0007

W: www.maplecarephysiotherapy.com E: info@maplecarephysiotherapy.com

Credit Card (Mandatory)

• If no payment is received 2 weeks after the appointment is completed, I understand that I am responsible for any fees incurred and any treatment fees

• The receipt will be sent to the card holder's email after payment completion
• I am providing valid credit card information below and authorization for use in case payment of account is required by myself:
Credit Card Type: MasterCard Visa AMEX Others:
Card Number
Expiry Date (mmyy)/
Expiry Duce (minyy)
CVV
Name of Card Holder
Name of Card Holder
Contact information for Card Holder (only if Card Holder is not the same as Client)
Phone number email
E-Transfer

Email

- After the appointment is completed an invoice will be sent to the email listed above
- If we do not receive a payment in 2 weeks the credit card listed will be charged
- Please send the E-Transfer to skalra@maplecarephysiotherapy.com

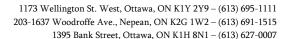
Private insurance

For us to claim your private insurance please fill out the following form:

https://maplecarephysiotherapy.com/files/forms/eClaims-Patient-Consent-Form.pdf

INFORMED CONSENT (Please read completely)

- MapleCare Physiotherapy Clinic is my health information custodian.
- In regard to telerehabilitation, I am aware of the following and give consent to the physiotherapists at MapleCare Physiotherapy Clinic
 - Toprovide services via telerehabilitation rather than in person.
 - For transmitting and storing of information and data from the telerehabilitation session.
 - For the participation of other health-care providers or my family member(s) in the provision of care as needed.
 - I understand that despite reasonable efforts to protect the security and confidentiality of electronic communication, there are still risks of technical failure due to measures beyond our control, and that it is not possible to completely secure the exchange of information. I agree not to hold MapleCare Physiotherapy responsible for any of the risks..



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- I understand that I have the right to terminate the telerehabilitation services, without affecting my right to future care of treatment.
- o I understand that emails would be used for some communication and transmitting patient information via emails poses some privacy risks. I understand these risks and allow email use for communication.
- o There may be limitations in the services that can be provided through electronic communications, dependent on the means of electronic communications being utilized
- A minimum of 24-hour notice is <u>required</u> for canceling an appointment to accommodate other patients in need of care. I am subjected to a fee of \$50.00 for no-show or cancellations made in less than 24 hours.
- Payment is due in full by cash, debit, credit or cheque for every visit. A receipt with all the required information will be provided.
- I give consent to the physiotherapists at MapleCare Physiotherapy Clinic for assessing and treating my condition(s).
- I understand that in order to provide safe treatment, my physiotherapist may need to communicate with my physician and/or other health care professionals regarding my condition and treatment, for which I give consent.

SIGNATURE	 DATE
Patient or Guardian	