MapleCare Physiotherapy & Neuro Rehab Centre

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

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 ____

*We send special offers and information to our patients via our email newsletters. You can unsubscribe anytime using the Unsubscribe button at the bottom page of the newsletter.

☐ I grant permission for MapleCare Physiotherapy Clinic to email me their newsletters.

How did you hear about us?

☐ Google, online ads, website
☐ Social media
☐ Street sign
☐ Referred by friend or family: _______________________________
☐ Others: _________________________
☐ Referred by Dr: ____

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:

1173 Wellington St. West, Ottawa, ON K1Y 2Y9 – (613) 695-1111
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☐ Credit Card
☐ E-Transfer
☐ Private Insurance
☐ Other: ________________________

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) __________ /____________

  CVV_____

  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.
    - 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.
    - 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 required 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