



LL 102-761 Brant Street • Burlington, Ontario • L7R 2H7
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Patient Name:		Primary Insurance Co:	
Date of Birth: yyyy/mm/dd:		Group Policy #	
Home Address:		ID #	
City:	Postal Code:	Name of Insured:	
Phone # :	Cell # :	Date of Birth of Insured: yyyy / mm / dd	
Email :		Auto Insurance (fill in below only if using Accident Benefits)	
Employer:	Occupation:	Auto Insurance Co:	
Work Phone # :	Work Fax #:	Policy #	Claim #
Family Doctor:	EMERGENCY CONTACT:	Adjuster Name:	
Referral Source:	Phone #:		
Doctor Phone # :	Doctor Fax # :	Adjuster Phone:	
		Adjuster Email:	

OFFICE POLICIES AND PROCEDURES

APPOINTMENTS:

Please be 5 – 10 minutes early and sign in for each of your appointments.

Late arrivals exceeding scheduled time by greater than 15 minutes will be re-scheduled.

Book your appointments at the beginning of each week for the following week.

Cancel your appointment if you are unable to attend, if you miss several appointments without reason, we may notify your physician or insurance company and you may be discharged.

Cancelled appointments or no show appointments, will result in a charge of the full appointment fee, if the clinic is not notified a minimum of 24 hrs prior.

SAFETY:

Wear clothing that is appropriate for exercise & treatment.

Children must be under adult supervision and are not to play with any equipment in the treatment area.

Please notify the treating therapist of any changes in your condition or if you are unsure about a treatment.

Please call for assistance immediately if you are in any discomfort during your treatment.

If you have inhalers or nitro spray, please have it with you at all times while in the clinic

MOTOR VEHICLE ACCIDENT (MVA):

A physician's referral is recommended.

The Accident Benefits Package (ABP) must be submitted to your insurance company as soon as possible (if you require assistance in completing the ABP, notify your treating therapist).

Any no show appointments will be charged the full visit fee.

NOTE: we are required by law, to bill any extended health plan you have before billing your car insurance company.

EXTENDED HEALTH CARRIER / THIRD PARTY BILLING:

Assessment fee is \$120.00 and is approximately 1 hour in length. One may or may not receive treatment on this day; treatment is dependent on how much is involved. A Standard treatment (15 min of focused care) is \$80. ½ hour (30 mins) of 1 on 1 treatment is \$160. 1 hour one on one treatment is \$320.

Shockwave treatment sessions are \$100.00 per session. Please speak to your provider to clarify which option is most beneficial for you.

Payment must be provided per visit. Please ask the office coordinator about payment methods.

Once payment has been received, if you require, administration will print corresponding claim forms for you to mail out and receive reimbursement directly from your insurance company. This will ensure that the claim form is correctly filled out and the respective insurance company sends you proper reimbursement.

PRIVATE PAYMENT:

A physician referral is recommended.

Assessment fee is **\$120.00**, for subsequent treatment fees, please discuss with your provider.

Payment must be provided per visit. Please ask the office coordinator about payment methods.

NOTE: If finances are an issue, please, discuss strategies to assist in your unique situation with the treating therapist

I have read and understand the above policies & procedures. I consent to the collection, use and disclosure of my personal information. The purpose of this collection is to provide assessment and treatment services relevant to my needs and to obtain information related to payment for services provided. The information collected may be disclosed to my referring or funding agency and discussed among my treatment team. I give permission for my physician, physiotherapist, treating therapist, insurance company, WSIB, employer, lawyer, or rehabilitation counselor to discuss any medical information pertinent to my treatment.

Signature: _____

Date: _____