



Unit 201,3323,34 St NW, Edmonton, Alberta, T6T 2K6, Ph: 780-450-3435, fax: 780-450-3495

Email: info@silverberryphysio.com

## **WCB Clinic Policies**

### **Cancellation No Show Policy**

In order to minimize disruptions to or schedule, we require no less than 24 hours notice for cancelling or rescheduling and appointment. Your attendance record is used by WCB to determine future treatment. WCB expects 3 sessions per week for 6 weeks, on approval of claim. The cancellation policy is in effect to ensure that our physical therapists are compensated for their time. Please be courteous to your therapist and other clients by respecting our policies.

### **Payment**

I acknowledge that I am responsible for the payments for the treatment I have received from Silverberry Physiotherapy clinic if the claims through CRP or private benefits have exhausted or if WCB or motor vehicle insurance companies deny the claim.

### **Personal Belongings**

The clinic cannot be held responsible for loss or damage to personal goods.

### **Consent for disclosure of Personal Information**

Silverberry Physiotherapy clinic is committed to the responsible collection, use and disclosure of personal information. I hereby authorize Silverberry Physio to either

- A) Release medical and personal information for the purpose of preparing a report for the purpose of preparing a report for my third party payer or
- B) Obtain any medical information that is relevant to my treatment (for example x-ray lab results).

### **Consent to Assessment and Treatment**

I acknowledge that these treatment may include, but are not limited to, soft-tissue mobilizations (stretching and message), joint mobilizations and or manipulations, active exercises (clinic and home program), modalities (ice, heat, ultrasound, electrical modalities), and functional activity retraining. I understand that physical therapy assessment and treatment requires physical contact and or use of electrical devices as well as exercises. I



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consent to such assessment and treatment, as explained to me by the physical therapist.

I Agree to Silverberry Physiotherapy Clinic Policies (if patient is under the age of 18, parent guardian is to sign):

Patient Signature	Witness Signature	Date

**Acknowledgement:**

By signing this document I acknowledge that there is always some risk of physical harm involved in any form of exercise or physical treatment and absolve the therapists employed by Silverberry Physiotherapy Clinic of any responsibility for injury incurred by myself during the course of physical therapy assessment or treatment. I also acknowledge that it is my responsibility to inform my treating therapist of any undue discomfort or side-effects from treatment. I understand that I may withdraw this consent and refuse further treatment at any time. (If patient is under the age of 18, parent guardian is to sign:



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WCB intake forms

Name: \_\_\_\_\_

Emergency Contac: \_\_\_\_\_

Address: \_\_\_\_\_

Emergency Contact Ph.: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_

Family Doctor: \_\_\_\_\_

Postal Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Home Ph: \_\_\_\_\_

**WCB**

WCB Claim: \_\_\_\_\_

Cell Ph: \_\_\_\_\_

WCB Case Manager: \_\_\_\_\_

Work Ph: \_\_\_\_\_

WCB Case Manager Ph.: \_\_\_\_\_

AHC # \_\_\_\_\_

WCB Case Manager Fax: \_\_\_\_\_

Email: \_\_\_\_\_

Work address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Email Address: \_\_\_\_\_

APPROVAL UNTIL: \_\_\_\_\_

STATUS DATE: \_\_\_\_\_

**WORK INFORMATION**

Company Name: \_\_\_\_\_

Work address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Contact Person: \_\_\_\_\_