2221 Keele Street, Suite 302
Toronto, ON M6M 3Z5
Phone:416-759-8099
Fax:416-759-9085
www.iwellness.ca

# PHYSIOTHERAPY FEE SCHEDULE

Regretfully, as of December 12, 2004, the Ontario Government has removed all OHIP coverage for physiotherapy services. This service interruption is expected to continue until legislated otherwise.

However, please note that many third party insurance coverage plans (through the workplace) still cover for these services. Patients should understand that they are required to pay for all services rendered and reports provided.

Motor vehicle accident clients or WSIB patients will not be required to pay up front for services rendered but will be held responsible for these fees and interest should coverage for their conditions become unavailable.

The service fees for regular or non-MVA treatments are as follows:
(Other fees are listed on the clinic website.)

**INITIAL VISIT........................................................$95.00**

**20 MIN ..................................................................$50.00**

**30 MIN ..................................................................$65.00**

**45 MIN ..................................................................$80.00**

**60 MIN ..................................................................$125.00**

All patients will receive a receipt at the end of the visit schedule for their records and/or submission to a third party insurance company.

______________________________
Print Patient's Name:

Date Signed: ________________________

______________________________
Signature of Patient

Please note that 24-hour appointment cancellation notice is required to avoid charges.

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# INFORMED CONSENT
# FOR PHYSIOTHERAPY

I hereby request and consent to the performance of Physiotherapy Treatment and assessment including various modes of physical therapy on me by the Physiotherapist named below.

I have had an opportunity to discuss with the Physiotherapist named below, the nature and purpose of Physiotherapy Treatments and any other related procedures. I understand that results are not guaranteed.

I further understand and am informed that, as in all health care, there are some very slight risks to treatment, including, but not limited to, muscle strains and sprains, disc injuries, and strokes, I do not expect the doctor or health professional named below to be able to anticipate and explain all risks and complications and I wish to rely on the Physiotherapist to exercise judgment during the course of the procedure which they feel at the time, based upon the facts then known, is in my best interests.

I have read the above consent. I have also had an opportunity to ask questions about content, and by signing below I agree to the above mentioned therapeutic procedure. I intend this consent form to cover the entire course of treatment for my present condition.

**TO BE COMPLETED BY PATIENT:**

Print Patient's Name: ______________________________________________

Signature of Patient : ______________________________

Date Signed: ___________________________________

**OFFICE USE ONLY**

Name: ___________________________________

Date: ___________________________________

Signature: ___________________________________

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# Health History Form

***The information requested below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information will be kept confidential unless allowed or required by law. Your written permission will be required to release any information.***

***Name:*****________________________________** ***Signature:*****__________________________**
**Home Phone:__________________________ Mobile Phone:________________________**
**City: ____________________________Prov.:_________________ Postal Code:______**
**Address:__________________________________________________________________**
**Occupation:__________________________ Date of Birth:___________________________**
**Email Address: ___________________________________________**
**The e-mail address is for the purpose of our communication with you and will not be used or sold for any reason.**
**Have you received Physiotherapy Before? ☐ Yes ☐ No**
**How were you referred to the clinic? __________________________________________**
**Please indicate conditions you are experiencing or have experience:**

**Cardiovascular**
- ☐ ***High blood pressure***
- ☐ ***Low blood pressure***
- ☐ ***Chronic Congestive Heart Failure***
- ☐ ***Heart attack***
- ☐ ***Phlebitis /Varicose Veins***
- ☐ ***Stroke/CVA***
- ☐ ***Pacemaker or similar device***

**Is there a family history of any of the above? ☐ Yes ☐ No**

**Respiratory**
- ☐ **Chronic Cough**
- ☐ **Shortness of breath**
- ☐ **Bronchitis**
- ☐ **Asthma**
- ☐ **Emphysema**

**Is there a family history of any of the above? ☐ Yes ☐ No**

**Infection**
- ☐ ***Hepatitis***
- ☐ ***skin conditions***
- ☐ ***TB***
- ☐ ***HIV***
- ☐ ***Herpes***

**Other Conditions**
- ☐ **Loss of Sensation, where?________**
- ☐ **Diabètes, onset:_______________**
- ☐ **Allergies /hypersensitivity to what?**

**_____________________________**
**Type of reaction:_________________**
- ☐ **epilepsy**
- ☐ **Cancer, Where? _______________**
- ☐ **skin conditions, what? __________**
- ☐ **Arthritis**

**Is there a family history of any of the above? ☐ Yes ☐ No**

**Head/Neck**
- ☐ **History of headaches**
- ☐ **History of migraines**
- ☐ **Vision problems**
- ☐ **Vision loss**
- ☐ **Ear problems**
- ☐ **Hearing loss**

**Women**
- ☐ **Pregnant ,due: __________**
- ☐ **Gynecological conditions, What?**

**__________________________**
**Overall, how is your general health?**
**______________________**
**Primary Care Physician:**
**__________________________**
**Address:___________________**
**_________________________**

**Current Medications: ___________________**

**Conditions it treat: _____________________**

**Are you currently receiving treatment from another health care professional? ☐ Yes ☐ No If yes, for what? ___________________**

**Surgery -date______________________**

**Injury- date ________________________**

**Do you have any other Medical conditions ( e.g. digestive conditions, hemophilia, osteoporosis, mental Illness) ☐ Yes ☐ No what?**
**_____________________________________________**
**Do you have any internal pins, wires, artificial joints or special equipment? ________________________________________**
**What? _________________________________________**
**Where? ________________________________________**

**What is the reason you are seeking Physiotherapy? Please include the location of any tissue or joint discomfort.**
**____________________________________________________**

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