

**The Edge Sport Physical Therapy Clinic  
PHYSIOTHERAPY REGISTRATION**

Name \_\_\_\_\_ Birth Date \_\_\_\_\_  
Last First Initial dd/mm/yy

Address \_\_\_\_\_ City \_\_\_\_\_ Prov. \_\_\_\_\_

Post Code \_\_\_\_\_ e-mail address: \_\_\_\_\_

Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

Alberta Personal Health No. (9 digits) \_\_\_\_\_ Sex : M F

Referring Physician: \_\_\_\_\_

Family Physician: \_\_\_\_\_

Consent to send assessment and treatment information to your doctor: **YES NO**

Have you had previous treatment for this current injury? (Physio, Chiro, Massage, Accup.) **YES NO**  
When & Where & Who \_\_\_\_\_ Ongoing care: **YES NO**

Is this a Post-Fracture or Post-Surgery condition? **YES NO** Date: \_\_\_\_\_

Publically funded physiotherapy is **only** eligible to the following clients:

1. Post Surgery (initial assessment and treatment and up to 6 subsequent visits).
2. Post Fracture (initial assessment and treatment and up to 6 follow up visits)
3. Post Procedure (ie non-surgical protocol achilles tendon rupture, manipulation under anaesthetic)
4. Very low income (ie on a Government subsidized program or proof of low income Line 260 of your Income Tax Return or Notice of Assessment– individual and Spouse/Partner).

Is this injury the result of a Motor Vehicle Accident? **YES NO** Date of MVA \_\_\_\_\_  
Claim# \_\_\_\_\_ Policy# \_\_\_\_\_ Insurance Co. \_\_\_\_\_

Is this a Workers Compensation Board claim? **YES NO**

**If yes, you will have to seek treatment at a WCB affiliated clinic.**

Are you a World Health Club Member? **YES NO**

Physiotherapy charges are:

\$110.00 for the Initial Assessment and Treatment

\$80.00 for each follow up visit (\$110.00 for extended visit for clients with complex or multiple problems)

Clients are responsible for submitting their receipts to their extended health plans for re-imburement.

**Certified Hand Physiotherapy : \$110.00 per session**

How did you find out about our Clinic:

- Advertisement     Sign     Website     Returning Patient     Yellow Pages  
 Doctor Referral \_\_\_\_\_     Coach/Teacher \_\_\_\_\_  
 Friend / Relative \_\_\_\_\_     Other Services at this location \_\_\_\_\_

Do you have any of the following or any other condition which your physiotherapist should be aware?

- Pregnancy     Metal Implant     Diabetes     High Blood Pressure  
 Infectious Disease     Cancer     Bleeding Disorder     Blood Thinners  
 Pacemaker     Epilepsy     Recent Surgery     IUD  
 Osteoporosis     Heart Disease     Allergies (latex, environmental): \_\_\_\_\_  
 Other: \_\_\_\_\_

MEDICATIONS? \_\_\_\_\_

**Private billings can be paid by Cash, Cheque, Debit or Visa/MC at the time of treatment. Patients may be invoiced monthly if they leave a signed imprint. WHC members may charge their club account. Please indicate below of the form your payment choice.**

Please try to avoid unkept appointments. Contact the receptionist as early as possible if you can not make your scheduled appointment. **A \$50 fee may be levied for unkept appointments and same day cancellations.**

**Consent:**

We ask you to sign in the space below in acknowledgment and understanding of your obligation and liability for the cost incurred by you at this clinic. (if you are under the age of 18 years, this must be signed by your parents.)

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

We ask you to sign in the space below in acknowledgement and understanding of your consent to initial physiotherapy assessment which may involve the physiotherapist asking you questions, observing your movement and posture, measuring your joint range of motion and muscle strength, assessing your nervous and vascular system. You are free to ask questions during the assessment and understand that you can stop the assessment at any point. (if you are under the age of 18 years, this must be signed by your parents.)

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

We ask you to sign in the space below in acknowledgement and understanding of your consent to physiotherapy treatment. This may include soft tissue work, manual therapy, spinal mobilizations/manipulation, electrotherapeutic modalities, thermal modalities, acupuncture, intramuscular stimulation, exercise, taping and education. Your therapist will explain to you the potential benefits, side effects and risks associated with each treatment technique prior to its usage. You are free to ask questions at any time before, during or after your treatment and subsequent reassessments. Please understand that you can stop the treatment and subsequent reassessments at any point in time. (if you are under the age of 18 years, this must be signed by your parents.)

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**This information is collected under the authority of The Health Information Act. The above mentioned information is collected to ensure proper assessment and treatment can be provided and to evaluate rehabilitation procedures.**

**Consent for collection of information:** I hereby consent to the collection, use, storage and disclosure of my personal information in accordance with the Edge Sport Physical Therapy Inc.'s privacy policy. The personal information collected is limited to that which is reasonable for purposes of providing physiotherapy treatment. I hereby acknowledge that a copy of the privacy policy is available to me and I may contact Barbara Lindsay BSc PT if I have any information privacy questions.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**PAYMENT SELECTION: Please check your payment choice.**

**1. Pay Each Visit**

DEBIT  CASH  CHEQUE  or VISA/ MC

**2. Monthly Invoice**

**VISA / MC** A signed imprint can be taken and the monthly charges will be put through towards the end of each month.

**WHC Account.** World Health Club members may invoice their account.  
**WHC Membership #** \_\_\_\_\_

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_