PHYSIOTHERAPY CONSENT FORM

CONSENT TO TREAT AND CONSENT TO COLLECT AND DISCLOSE INFORMATION:

In accordance with the Data Protection Commissioner (Ireland) www.dataprotection.ie/viewdoc.asp?DocID=4
Department of Health and Children, HSE National Consent Policy. 2013 www.hse.ie Superphysiofit Physiotherapy needs your informed consent to provide assessment and treatment services to you and to collect and use your personal information. We want you to understand the services we provide, the cost involved, and what we may do with your personal information.

1. CONSENT TO TREATMENT:

I agree to participate in assessments and treatments given by the physiotherapist and the support personal. I understand that the assessment and treatment services I undergo may be administered by the treating provider and by the support staff under the supervision of the treating provider. I acknowledge that my treatment providle risks and side effects of the proposed treatment. I acknowledge that I have read, understand, and agree to the policies and procedures of outpatient , private Superphysiofit Clinic that are published at www.superphysiofit.weebly.com.

2. CONSENT FOR THE COST OF PHYSIOTHERAPY SERVICES:

I agree that I have been informed of the costs of the assessment and the treatments/services provided to me. I understand Superphysiofit Physiotherapy Clinic may under some circumstances bill these services to my insurance company or a third party responsible for the payment and that I am responsible for paying in full the balance of any amount not thus covered in advance. I also understand that I will be billed for all the services rendered that may not be covered at all by the insurance company.

3. CONSENT TO COLLECT AND DISCLOSE INFORMATION:

Personal information that Glen Abbey Physiotherapy collect, retain, use and disclose may include without limitation, your age, contact information, occupational information, personal health information, medical history and other information deemed necessary to fulfill the following purposes:

1. To provide assessment and treatment services.

2. To provide/obtain to/from Third Party Payers, Physicians and Legal Counsel with/from progress reports, assessment findings, diagnostic tests/medical investigations, resulting from the services provided to you or in order to optimize the treatment to be provided to you.

3. To contact you about services you have received or services we're offering. This may include (without limitation); follow-up calls or appointment reminders, newsletters, notices of promotions and special events.

I hereby request and consent to the performance of physical assessment/treatment procedures on me by the Chartered Physiotherapist identified below and the support staff. My consent is voluntary and I intend this consent form to cover the entire course of assessment/treatment for my present condition, commencing on the date indicated on the Initial Assessment Form provided by the Physiotherapist

SIGNATURE

Cancellation Policy

Please be advised that we have a **Cancellation Policy** in effect.

You **MUST** give 24 hours of notice to cancel your appointment.

Any missed or cancelled appointment within 24hrs will be charged a 70% cancellation fee.

This fee is not eligible to be reimbursed by your extended health provider. You will be responsible for covering this cost.

If you have any questions or concerns, please discuss this matter with the Physiotherapist

I understand and agree with Superphysiofit Physiotherapy Clinic Cancellation Policy. I am aware that, should I not give 24 hours of notice to cancel my appointment, I will be invoiced a 70% fee.

SIGNATURE

Initial Health Screening Form

Common sense is your best guide in answering these few questions. Please read them carefully and check the YES or No box opposite the questions.

YES NO

☐ ☐ 1. Has your doctor ever told you that you have heart or lung problems?

☐ ☐ 2. Have you ever had heart related problems?

☐ ☐ 3. Do you frequently feel any chest discomfort?

☐ ☐ 4. Do you often feel faint or have spells of severe dizziness?

☐ ☐ 5. Has your doctor ever told you that you have high blood pressure in the past or are you presently taking any medication for blood pressure?

☐ ☐ 6. Other then the injuries that bring you to our clinic, are you aware of any bone, back or joint problems that may be, or could be aggravated by exercise (i.e. arthritis)?

☐ ☐ 7. Have you ever had an episode of exercise-induced asthma, that is, severe wheezing, coughing or severe shortness of breath brought on by exercise or do you ever have unaccustomed shortness of breath at rest or at mild exertion?

☐ ☐ 8. Do you have episodes of laboured or difficult breathing during the night where you have to sit-up to breath?

☐ ☐ 9. Have you been told by your doctor that you have diabetes?

☐ ☐ 10. Are you over 65 and involved in regular exercises?

☐ ☐ 11. Is there a good reason, not mentioned here, why you should not engage in exercise even if you wanted to?

☐ ☐ 12. Are you pregnant?

Comments:	

I Hereby certify that the above information is correct.

Name		Signature		Date	/ /

Any “YES” reasons concerning cardiovascular, pulmonary, or metabolic problems may not engage in any fitness or exercise program until a medical clearance form is completed and signed by your GP or Consultant.