



Athletic Quest international Inc. Elena Ojolic B.Sc.PT

**Myofascial Release/Physical Therapy
PATIENT INFORMATION**

Date: _____

Surname: _____

First Name: _____

Middle Initial: _____

Address: _____

City: _____

Province: _____

Postal Code: _____

Phone Numbers: Area Code Number Extension

Home: _____ _____

Phone (bus): _____ _____

Phone (cell): _____ _____

Email: _____

Emergency Contact: _____ Phone Number: _____

Date of Birth (D/M/Y) _____ Age: _____ Sex: M F

Current Motor Vehicle Claim Y or N

Insurance Provider: _____ Phone # _____

How did you hear about us? Web Site Referral _____ Sign

Type of Work: _____ Employer: _____

Athletic Quest International Inc. Elena Ojolic B.Sc.PT

Myofascial Release/Physical Therapy Consent Form

Name: _____

Date: _____

I hereby give permission to the physical therapist to do an assessment and/or administer treatment for the purpose of soft tissue rehabilitation.

I understand that the assessment and treatment for physical therapy at Summit Integrated Health Centre, Athletic Quest International is NOT COVERED under the Alberta Health Care Insurance Plan. I understand that I am fully responsible for all assessment and treatment costs upon receipt of service.

THE COST PER ASSESSMENT AND TREATMENT SESSION IS \$110.00.

Payments may be made by cash, cheque, debit, Visa, & M/C. Receipts are issued per visit. I understand that reimbursement for assessment and/or treatment costs by any insurance plan is the sole responsibility of the client.

I also understand that any release of information, including treatment notes, progress reports and medical legal reports will NOT be released without my written consent detailing what information is to be released and to what source it is to be released to. (Physician, Insurance, Therapist)

I do consent to the release/sharing of information (including medical reports, chart notes and history) between therapists within Summit Integrated Health Centre, Athletic Quest International for the purpose of comprehensive assessments and treatment.

I allow the release of information to the following outside sources only as listed below:

Initial _____

I understand that **twenty-four (24) hours notice of cancellation** of an appointment is required. We have an answering machine on which a message can be left when we are not in the office. A time and date is stamped when the message is left. Any cancellations that are NOT made 24 hours in advance, the full amount of the appointment will be charged (unless there is mediating circumstances). The cost of the cancelled appointment will be the responsibility of the client.

Signature: _____

Therapist signature: _____

Clinic Information

* Please Read and Sign

Office Hours

Monday 9 – 5 pm	Tuesday 8 – 5 pm	Wednesday 9 – 5 pm	Thursday 8 – 5 pm	Friday 8 – 12 pm
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Pricing

PAYMENT IS DUE WHEN SERVICE IS RENDERED. Payment is accepted in the form of cash, cheque, debit card, Mastercard and Visa.

Service

Physical Therapy \$ 110.00
(MFR, LDT, Visceral Manipulation)

Missed Appointments \$20.00 \$20.00

Upon request, our office will be happy to print you statements to submit to your insurance company for reimbursement. **WE DO NOT BILL SECONDARY INSURANCE COMPANIES ON YOUR BEHALF**, but we will be happy to assist you with your individual insurance forms.

Signature

Date