STATEMENT OF UNDERSTANDING FOR PHYSIOTHERAPY COVERAGE

COMMUNITY REHABILITATION PROGRAM (CRP):

You will be assessed by a physiotherapist who will rate you on a scale of 1-15 to determine if you are eligible for coverage by the CRP.
If you rate **seven or higher,** you will be covered for TWO more treatments for one body part (e.g. knee, shoulder, lower back, etc.) Your physiotherapist will discuss future appointments and treatments with you. If you rate **below seven,** you will be required to pay privately for your treatments. You can use your personal health benefits or private insurance. The fees are $60 for **one** body part.

WORKERS' COMPENSATION BOARD (WCB):

If you have a work related injury, your physiotherapist will assess you and send an initial report to WCB for approval and acceptance of payment for your treatments. Your physiotherapist will discuss future treatments and attendance with you. If you do not already have a claim established, you might have a delay in starting your treatment program.

I understand that if for any reason the CRP, WCB, my personal health benefits or insurance does not pay for my physiotherapy treatments, I will be responsible for paying all treatment costs at $60 for <u>each</u> body part treated.

Please check off which of the following extended healthcare benefits you have for physiotherapy

___ Personal Insurance – Insurance Company _____

___ Spousal Work Benefit Plan – Insurance Company _____

___ Work Health Benefit Plan ___ Veterans Affairs

___ Military ___ RCMP

_____ _____ _____

Signature Print Name Date

CONSENT TO ASSESSMENT AND TREATMENT

I, _____, hereby authorize and grant permission to the physiotherapist(s) and their assistant(s) to carry out examinations, procedures and treatments as may be necessary. I also authorize and grant permission for the sharing of my information with all necessary professionals, including **third party payers, legal council and medical personnel e.g. doctor, chiropractor, massage therapist physiotherapist, etc.** who are providing services to me. I am aware of my option to discontinue treatments at any time after discussion with my physiotherapist.

I acknowledge that no guarantees have been made to me regarding the outcome of services.

_____ _____ _____

Signature Print Name Date