

**COOPER PHYSIOTHERAPY  
CLINIC  
OSGOODE**

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**COOPER PHYSIOTHERAPY  
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## Consent Form

**NOTE TO CLIENT:** We want your informed consent. This means that we want you to understand the services we hope to provide to you, the cost involved, and what we do with personal information we obtain about you. If you have a question regarding anything of this, please ask.

### CONSENT FOR TREATMENT

I agree that I am attending Cooper Physiotherapy Professional Corporation to receive either physiotherapy or massage therapy treatment. I understand that the Physiotherapist and/or the Massage Therapist will explain his/her findings, discuss treatment goals and explain all aspects of care. I understand that some aspects of my treatment maybe delegated to physiotherapy aides. I understand that I can ask questions and can withdraw consent for treatment at any time.

### CONSENT FOR THE COST OF OUR SERVICES

I understand that for the provision of professional services Cooper Physiotherapy Professional Corporation will charge me:

Physiotherapy Assessment	\$ 90.00	Custom Orthotics (1 pair)	\$400.00
Physiotherapy Treatment	\$ 65.00	Custom Orthotics (2 pair)	\$550.00
Secondary Assessment	\$ 70.00	Photocopy of Chart	\$175.00
Massage Therapy 30 minutes	\$ 60.00	Completion of Medical Form	\$ 80.00
Massage Therapy 45 Minutes	\$ 75.00	Home Visit Assessment	\$115.00
Massage Therapy 60 minutes	\$ 85.00	Home Visit Treatment	\$85.00
Massage Therapy 90 Minutes	\$135.00	Pelvic Floor Assessment	\$130.00
		Pelvic Floor Subsequent	\$100.00

I understand that there is a 24 hour cancellation policy in effect and that I will be charged \$25.00 for any missed appointments. I agree to pay for these services upon receipt and understand that overdue accounts will be charged 3% per month. I understand that NSF cheques will be charged a \$25.00 administration fee.

### CONSENT FOR PERSONAL INFORMATION

I understand that to provide me with physiotherapy and or massage therapy goods and services, Cooper Physiotherapy Professional Corporation will collect some personal information about me (e.g telephone numbers, address, date of birth, health history, OHIP number.)

I have reviewed Cooper Physiotherapy Professional Corporation's Privacy Policy about the collection, use and disclosure of personal information, steps taken to protect the information and my right to review my personal information. I understand how the Privacy Policy applies to me. I have been given a chance to ask any questions I have about the Privacy Policies and they have been answered to my satisfaction.

I understand that, as explained in the Policies and Procedures for Personal Information, there are some rare exceptions to these commitments.

I agree to Cooper Physiotherapy Professional Corporation collecting, using, and disclosing personal information about me as set out above and in the Cooper Physiotherapy Professional Corporation's Privacy Policy.

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**PRINTED NAME:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_