

OFFICE POLICIES AND PROCEDURES

In our effort to provide the highest quality of care to each of our patients, we have compiled our office policies for you.

APPOINTMENTS:

- If you would like reminders of your appointments via email or phone, please ask the Office Administrator.
- To ensure suitable appointments, we recommend you book your time two weeks in advance.
- All cancelled or missed appointments with less than 24 hours notice may be subject to a charge of \$25.00.

SAFETY:

- Wear clothing that is appropriate for exercise.
- Please notify your treating therapist of any change in your condition or anything you are unsure about.
- Please call for assistance immediately if you are in any discomfort during your treatment.
- If you have inhalers, an EpiPen, or nitro spray, please have them with you at all times while in the clinic.
- If you have severe allergies please make your therapist aware of this on your first visit.

OHIP (Applicable at OHIP funded clinics only):

- A Physician referral for physiotherapy is required and we are only able to treat one area per session.
- Assessment and/or additional service fees will be discussed with you on your first visit to the clinic.
- You are covered for 100 visits per year if you are: under the age of 20 or 65 and over, are on ODSP, Family Benefits or Ontario Works.
- You are covered for 50 visits per year if you were hospitalized overnight for your injury, are between 20 and 64 years old and have a referral from the physician who was treating you in the hospital.
- You may also be eligible for an additional 50 visits with a new doctor's referral.

MOTOR VEHICLE ACCIDENT (MVA):

- A physician's referral is recommended, but only required if needed for your insurance company.
- You must submit your Accident Benefits Package (OCF 1) to your insurance company as soon as possible.
- Please provide our office with all of your relevant information (insurance company, date of accident, claim number etc.) so that we can process your claim.
- We are required by law to bill any extended health plan you have before billing your car insurance company.
- Please be aware that **you are responsible for forwarding all payments made to you** by your insurance company to our office, for treatment or services received at our facility.
- If payment is not forwarded once it is obtained from your insurance carrier, we reserve the right to take appropriate action to recover the charges accrued for your treatment.

EXTENDED HEALTH CARRIER BILLING:

- A physician's referral is only required if needed for your insurance company.
- You will need to provide us with your Policy and ID numbers if you would like us to help you check your coverage.
- For direct billing, you assign the clinic the benefits to which you are entitled for this claim.
- Please be aware that **you are responsible for forwarding all payments made to you** by your insurance company to our office, for treatment or services received at our facility.
- If payment is not forwarded once it is obtained from your insurance carrier, we reserve the right to take appropriate action to recover the charges accrued for your treatment.

WORKERS SAFETY AND INSURANCE BOARD (WSIB):

- A physician's referral is not required.
- If you are attending treatment as a result of a work injury, you must report your injury to the appropriate agencies.
- You are responsible for providing our office with your claim number as soon as it is issued.
- Please be aware that if your claim through WSIB is denied, you are responsible for any and all charges accrued for your treatment at our facility.

PRIVATE PAYMENT:

- A physician's referral is not required.
- Assessment and Treatment fees will be discussed with you on your first visit to the clinic.
- Payment for the treatments received at our facility, are to be paid in full after each visit.

I have read and understand the above policies and procedures. I consent to the collection, use and disclosure of my personal information. The purpose of this collection is to provide assessment and treatment services relevant to my needs and to obtain information related to payment for the services provided. The information collected may be disclosed to my referring physician or funding agency and discussed among my treatment team.

Signature: _____

Date: _____