BEDFORD ORTHOPAEDIC HEALTH CENTRE-PHYSIOTHERAPY
200-1093 Bedford Highway
Bedford, NS B4A 1B7
Tel#: 902.835.1932
Fax#: 902.832.1374

PRIVATE INSURANCE COVERAGE

The fees for private physiotherapy treatments are not covered by the provincial medical plan, MSI. Most health insurance plans such as Blue Cross & Great West Life, reimburse all or a percentage of the cost. However in most cases we are not permitted to bill them directly with the exception of most Medavie Blue Cross. Upon payment we will issue an official receipt for you to submit to your insurance carrier for reimbursement. Plans vary considerably so **PLEASE CHECK YOUR PLAN TO DETERMINE THE AMOUNT OF COVERAGE YOU HAVE AND THE TERMS OF YOUR REIMBURSEMENT (including any customary charges if applicable).** Some plans require a referral by a physician.

TREATMENT FEES

The fees for Physiotherapy are available at the front desk.

PAYMENT

Payments may be made by cash, cheque, MasterCard, Visa or debit after each visit,

PATIENT INFORMATION

Name: _____ Gender: _____ Date of Birth: _____

Address: _____ City/Province: _____

Postal Code: _____ Home Tel#: _____-_____ Work Tel#: _____-_____

Cell#_____-_____ Email_____

Health Card #_____

Area of Treatment : _____ Date of Onset: _____

Referring Physician: _____ Family Physician: _____

Type of Medical Plan: _____

1) Why is it important that you have this problem fixed now?_____

_____

2) What are two main things that you want to achieve from today's consultation?_____

_____

_____

Other Health Related Issues? Please circle the following relevant to your health.

High Cholesterol	Diabetes	Heart Problems	Allergies	History of Cancer
High Blood Pressure	Epilepsy	Fracture Pins/Plates	Pacemaker	Pregnant
Fainting Dizziness	Infections	Bowel/Bladder	Sensitivities	Other_____:

_____

Are you taking any medications? _____

Any X-rays taken related to the referral? _____

Are there any related surgeries? _____

What is your occupation? _____

What are your recreational or sported related activities? _____

Emergency Contact: _____ Tel#: (Day) ___-_____ (Evening) ___-_____

Turn over page.....

CONSENT FORM

I, _____, give consent to the assessment and treatment by a physiotherapist employed at the Bedford Orthopaedic Health Centre. I understand the physiotherapist will discuss the clinical findings and inform me of the available treatment options. I will communicate to the physiotherapist any questions or concerns with respect to treatment and at any time I have the right to terminate treatment.

I, _____, give consent for Bedford Orthopaedic Health Center to communicate and send reports to my Family Practitioner, and referring health professional.

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24 HOUR CANCELLATION & MISSED APPOINTMENT POLICY

The Bedford Orthopaedic Health Centre asks all clients to **respect our 24-hour cancellation or missed appointment policy** as this time was set aside for you. With less than 24 hours notice, it is difficult for the clinic personnel to contact other patients who wish to be seen. Therefore, failure to comply, **50% of the treatment cost will be billed to you directly and not to your health insurance plan(s)**. This does not apply to situations of inclement weather or if you feel it is unsafe to travel to your appointment or have a communicable illness.

In the event of **three (3) missed appointments**, without cancellation, patients will be **discharged** from Physiotherapy services.

I have reviewed and understood all information on both sides of this form.

Patient Name: _____

Patient's Signature: _____ Date _____

Witnessed: _____

Witness Signature: _____ Date: _____

HOW DID YOU CHOOSE US!

- o Physician Recommendation
- o Internet/Google Search/Social Media
- o Family and Friends Recommendation
- o Location
- o Other_____

03/27/2018

200-1093 Bedford Highway
Bedford, NS B4A 1B7
Tel # 902.835.1932 Fax # 902.832.1374 Email: mariaradelich@gmail.com

Bedford Orthopaedic Health Centre-Physiotherapy – Maria Radelich, PT

PELVIC FLOOR PHYSIOTHERAPY

GENERAL CONSENT FOR EVALUATION AND TREATMENT

I acknowledge and understand that I have been referred to **Maria Radelich, PT** for evaluation and treatment of Pelvic Floor Dysfunction. I understand that to evaluate my condition it may be necessary, initially and periodically, to have my physical therapist perform and internal pelvic floor muscle exam to assess strength, range of motion, scar mobility and muscle length. Such evaluation and treatment may include, but not limited to, the following: observation, palpation, use of vaginal cones, vaginal or rectal sensors for biofeedback and/or electrical stimulation, exercise, soft tissue mobilization, education, instruction and neuromuscular techniques of the perineal area. Treatment may also include joint mobilization, modalities such as ultrasound and electrical stimulation, and _____.

I hereby request and consent to the evaluation and treatment to be provided by the physiotherapist: **Maria Radelich, PT**

_____

DATE: _____ **Patient Name:** _____

(Please Print)

Patient Signature: _____

(Patient Signature)

_____

(Signature of Parent or Guardian (if applicable)