

131 Wharncliffe Rd  
London Ontario N6J 2K4  
Tel: 519-434-3881  
Fax: 519-434-3887  
www.neuphysio.com



Client Name: \_\_\_\_\_  
Claim #: \_\_\_\_\_  
D.O.B. \_\_\_\_\_

(P) (NC) (C) (W)  
*Internal Use Only*

## Neuphysio Referral Intake Form

### Referral Source

Date of Referral: \_\_\_\_\_  
Referral Source (Name) \_\_\_\_\_ Title: \_\_\_\_\_ Contact #: \_\_\_\_\_  
Referral Company: \_\_\_\_\_ Fax #: \_\_\_\_\_  
Address: \_\_\_\_\_  
Email: \_\_\_\_\_

### Client Information

Client Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_ Male  Female   
Address: \_\_\_\_\_  
Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Email: \_\_\_\_\_  
Alternate Contact: \_\_\_\_\_ Contact #: \_\_\_\_\_  
Alternate Contact: \_\_\_\_\_ Contact #: \_\_\_\_\_  
**Claim Number:** \_\_\_\_\_ **Date of Loss:** \_\_\_\_\_

### Diagnoses

\_\_\_\_\_

### Notes

\_\_\_\_\_

### Billing Information

Name of Adjuster: \_\_\_\_\_ Company: \_\_\_\_\_  
Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_ Email: \_\_\_\_\_  
**Extended Health Benefits ----- Yes No**  
Company Name: \_\_\_\_\_ Policy #: \_\_\_\_\_  
Address: \_\_\_\_\_ Name of Plan Member: \_\_\_\_\_

### Team Members

Name	Relationship	Contact #
_____	_____	_____
_____	_____	_____
_____	_____	_____

# NEUPHYSIO CLINIC

## CLIENT RIGHTS AND RESPONSIBILITIES

### Client Bill of Rights (From Bill 173 – Part 111)

A person receiving a community service has the right to:

- Be treated with courtesy and respect and be free from mental, physical and financial abuse by the service provider.
- Be dealt with by the service provider in a way that fully recognizes the person's dignity and privacy that promotes independence.
- Be treated in a way that recognizes the person's individuality and is sensitive and responsive to the person's needs and preferences.
- Be told who is responsible for whom and who is providing the person's care.
- Participate in the assessment of his/her requirements for service, provision, and if eligible for community service, to participate in the development of the service plan.
- Give or refuse consent to the provision of service.
- Raise concerns in connection with the service provided without fear of retaliation.
- Have the service provider clearly explain their services and how they work.
- Have his/her records kept confidential, in accordance with the law.

### Client Responsibilities

- To cancel visits when not available with as much advanced notice as possible.
- To be present and prepared for the service provider visit.
- To be present and participate in ongoing assessment and discharge planning.
- To provide all required information and sign the necessary releases in order to receive services.
- To be involved in care planning and follow the mutually agreed upon plan.
- To inform service providers of changes in condition as soon as possible.
- To accept the scope and limitations of the services provided.
- To strive to be as independent as possible.
- To treat service providers with courtesy and respect.
- To respect the ethnic, cultural and religious values of the service providers.



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## Consent for Assessment

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Date of Accident: \_\_\_\_\_

Claim #: \_\_\_\_\_

CLIENT'S  
NAME: \_\_\_\_\_

PARENT/GUARDIAN/POWER OF ATTORNEY/  
AUTHORIZED PERSON (REPRESENTING  
THE CLIENT):

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

I, as client/parent/guardian/power of attorney/authorised person, hereby provide my consent for NEUPHYSIO CLINIC to conduct a physical and/or functional assessment of my abilities. I understand the information obtained will be utilized to facilitate the administration of health services and health planning and for no other purposes, and that the confidentiality of the information will be maintained.

List assessments below:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I understand that it is my responsibility that prior to and throughout the assessment process, that I fully disclose any relevant medical information as it pertains to my health status.

By signing this consent form, I agree to participate in this assessment. I have been informed of the nature, purpose and parameters of the requested assessment. I understand that my participation in this assessment is voluntary and I am free to decline or discontinue the assessment or any part thereof.

My signature below indicates that I have read and understood the information in this consent form.

\_\_\_\_\_  
Signature of client/parent/guardian  
Power of Attorney/authorised person

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

If applicable, translated by the attending interpreter \_\_\_\_\_, from  
\_\_\_\_\_ (company Name).



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## Consent for Treatment

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Date of Accident: \_\_\_\_\_

Claim #: \_\_\_\_\_

CLIENT'S  
NAME: \_\_\_\_\_

PARENT/GUARDIAN/POWER OF ATTORNEY/  
AUTHORIZED PERSON (REPRESENTING  
CLIENT)

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

I, as client/parent/guardian/power of attorney/authorised person, hereby provide my consent to the following treatment:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I have been informed about the following:

- What the treatment is.
- Who will be providing the treatment.
- The reason why I should have the treatment.
- The alternatives to having the treatment.
- The important effects, risks and side effects of the treatment, and
- What would happen if I did not have the treatment.

I understand the explanation and have no further questions. My consent is voluntary. I also understand that I can revoke my consent at anytime in communication with my therapist.

\_\_\_\_\_  
Signature of client/parent/guardian  
Power of Attorney/authorised person

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

*Valid for Twelve (12) months from date of signature*

**Note:** *Additional Treatment recommendations cannot be added to this form after being signed and dated. A new form must be completed as needed.*



# NEUPHYSIO CLINIC CANCELLATION POLICY

24 HOUR NOTICE IS REQUIRED FOR ALL  
CANCELLED APPOINTMENTS.

THERE WILL BE A **\$25.00 CHARGE** FOR A LAST  
MINUTE CANCELLATION.

TO CANCEL OR RESCHEDULE AN APPOINTMENT:

- Call our office immediately.
- Provide your name, date & time of your appointment, and your therapist's name.
- For inquiries, compliments or complaints, call our Clinic Manager at 519-434-3881.

***IT IS YOUR RESPONSIBILITY TO  
CANCEL OR RESCHEDULE YOUR  
APPOINTMENTS WITH AS MUCH  
ADVANCE NOTICE AS POSSIBLE.***



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**Informed Consent For The Collection and Release of Personal Information**

Client's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Parent/Guardian/Power of Attorney/Authorized person representing the Client: \_\_\_\_\_

**COLLECTION OF PERSONAL INFORMATION**

I understand that in order to provide me, or the above named client with \_\_\_\_\_ goods and services, NEUPHYSIO will collect health and personal information relevant to the services being provided.

I understand that I have a right to review my personal information collected by NEUPHYSIO. I am aware of my right to be given the opportunity to ask any questions or seek clarification. I understand that NEUPHYSIO has a policy and procedure in place for the proper collection, use and disclosure of personal health information as required by PIPEDA.

**RELEASE OF PERSONAL INFORMATION**

I hereby authorize \_\_\_\_\_ of NEUPHYSIO to exchange medical and/or other information as necessary with the persons/agencies listed below. I understand that this information will be used to facilitate the administration of medical/rehabilitation services, planning, and/or advocacy on my behalf, or on behalf of the above named client and for no other purpose. I understand the confidentiality of the information will be maintained. I understand that I have a right to withdraw my consent at any time during the rehabilitation process.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
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\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of client/parent/guardian/power  
Attorney/authorized person.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

\* This consent is valid for a twelve (12) month period.



## **NEUPHYSIO PRIVACY STATEMENT**

### **THE NEUPHYSIO PRIVACY POLICY IS AS FOLLOWS:**

- Maintaining privacy of personal information is an important principal to NEUPHYSIO.
- NEUPHYSIO and its personnel collect only the information that may be necessary for your care.
- Your request for care from a NEUPHYSIO therapist implies consent for our collection, use and disclosure of your purposes related to your care.
- Personal information about you may be shared within the organization, but on a limited, “need to know” basis only, where required for your health care.
- Office personnel have limited and supervised access to certain types of information, but only as is required in order to deliver services to you (i.e. filing, billing, etc).
- Your personal information is kept confidential at all times. It is stored securely and only for as long as required by legislation, after which time it is destroyed.
- Your personal information may be shared with third parties. Disclosure of this information will be only with your written consent.
- You have the right to look at your information and to ask for corrections to any factual information, if you believe that there is a mistake. Please ask your therapist for details.
- You have the right to obtain copies of your records. There may be a nominal fee for this service.
- You have the right to request a copy of our privacy policy. Ask your therapist to obtain one for you.

*If you would like to discuss our privacy policy in more detail, or have specific questions or complaints about how your information is handled, you may contact NEUPHYSIO Clinic Manager Sari Shatil at 51-434-3881.*