PRO SPORT
REHAB & FITNESS

Physical Therapy
Athletic Therapy
Chiropractic Care*
Massage Therapy*
Acupuncture
Exercise Therapy

#6 – 2345 Millar Ave Saskatoon, SK S7K 2Y3

INFORMED CONSENT TO ASSESSMENT AND TREATMENT

I hereby request and consent to the performance of assessment and treatment procedures at Pro Sport Rehab & Fitness, including various modes of Physical Therapy, Athletic Therapy, *Massage Therapy/Cupping, *Occupational Therapy, provided by the professional staff and/or those working in this clinic authorized by those staff. _____ **(initial)**

I will have an opportunity to discuss with my therapist, the nature and purpose of the treatment procedures. I acknowledge that no assurance or guarantee is provided to me as to the results of the treatment. I further understand that, as in all health care there are some very slight risks to treatment, including, but not limited to, muscle strains and sprains, disc injuries, and strokes. I do not expect the health professional to be able to anticipate and explain all the risks and complications. I wish to rely on the professional staff to exercise judgement during the course of the procedure(s) which they feel at the time, based upon the facts then known, is in my best interests. _____ **(initial)**

I acknowledge and understand that the therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my Therapist and disclosed all medical conditions affecting me. It is my responsibility to keep the Therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge. I consent to the release of any information that is deemed necessary to assist in the assessment and treatment of any condition that I consult Pro Sport Rehab & Fitness and/or a professional about. This information may be released to another health care practitioner, health care facility or third party (WCB/SGI). I understand that administration will make a reasonable attempt to contact me and explain the purpose of the release on information and that I can deny the request. If I cannot be contacted, my signature gives consent for the release of my information. _____ **(initial)**

I have read the above noted consent and I have had the opportunity to question the consent and my therapy. By signing this form, I agree to the above-named procedures. I intend this consent form to cover the entire course of my treatment for my present condition and for any future condition(s) for which I seek treatment at this clinic.

X_____ _____
Patient Name Date

X_____ _____
Patient Signature or Parent/Guardian (if minor is under 16) Relationship to Patient (if minor is under 16)

_____ _____
Witness to Signature (Therapist) Date

OVER →

PRO SPORT REHAB & FITNESS

Physical Therapy Massage Therapy*
Athletic Therapy Acupuncture
Chiropractic Care* Exercise Therapy
#6 – 2345 Millar Ave Saskatoon, SK S7K 2Y3

MISSED APPOINTMENT POLICY

Pro Sport Rehab & Fitness understands that unforeseen circumstances/emergencies can happen forcing you to cancel or reschedule your appointment. If you are unable to keep your appointment, **please notify us as soon as possible** (**preferably 24- hours' notice**). You can cancel appointments by calling (306) 249-6868 or by emailing us at: frontdesk@prosportrehab.com.
As a courtesy, an appointment reminder text msg or email to you is made/attempted one (1) business day prior to your scheduled appointment. **NOTE**: Appointment reminders are not to be relied upon; if our computer system malfunctions for any reason, Pro Sport Rehab & Fitness staff will not be held responsible for this error, you are still responsible for remembering your appointment.**

PLEASE REVIEW THE FOLLOWING POLICY:

1. Please cancel *and reschedule* your appointment **with as much notice as possible**; there is a waiting list to see the therapists at *Pro Sport* and whenever possible, we like to fill cancelled spaces to shorten the waiting period for our patients.
2. If you do not present to the office for your appointment, this will be documented as a "Missed" appointment – we will waive the fee for the first offense.
3. After the first "Missed" appointment, you will receive a phone call or letter explaining that you have broken our policy and we will assist you to reschedule this appointment.
4. If you have 2 "Missed" appointments within a one-year time period, you will receive a warning letter from our office and will be assessed a **$30.00 fee**.
5. A "Missed" appointment will apply for each appointment thereafter within a one-year time, and you will receive a **$30.00 fee** for each missed appointment.
I have read and understand Pro Sport Rehab & Fitness' Missed Appointment Policy. I understand it is my responsibility to plan appointments accordingly and notify Pro Sport Rehab & Fitness appropriately if I cannot keep my scheduled appointments. I understand that if I have any questions regarding this policy, the staff at Pro Sport Rehab & Fitness would be happy to answer them for me.

X_____ _____
Patient Name Date

X_____ _____
Patient Signature or Parent/Guardian (if minor is under 16) Relationship to Patient (if minor is under 16)

_____ _____
Staff Signature Date

MISSED APPOINTMENT POLICY FOR *WCB* and *SGI* CLIENTS

If you are unable to keep your appointment, **please notify us as soon as possible** (**preferably 24-hours' notice**). You can cancel appointments by calling (306) 249-6868 OR by emailing us at: frontdesk@prosportrehab.com.
As a courtesy, an appointment reminder text msg or email to you is made/attempted one (1) business day prior to your scheduled appointment. **NOTE**: Appointment reminders are not to be relied upon; if our computer system malfunctions for any reason, Pro Sport Rehab & Fitness staff will not be held responsible for this error, you are still responsible for remembering your appointment.**
Your attendance record is recorded for WCB/SGI purposes. Please be advised that Pro Sport Rehab & Fitness is required to notify WCB/SGI of any appointments where you no show or cancel.
I have read and understand Pro Sport Rehab & Fitness' Missed Appointment Policy. I understand it is my responsibility to plan appointments accordingly and notify Pro Sport Rehab & Fitness appropriately if I cannot keep my scheduled appointments. I understand that if I have any questions regarding this policy, the staff at Pro Sport Rehab & Fitness would be happy to answer them for me.

X_____ _____
Patient Name Date

X_____ _____
Patient Signature or Parent/Guardian (if minor is under 16) Relationship to Patient (if minor is under 16)

_____ _____
Staff Signature Date