Bourassa & Associates

REHABILITATION CENTRE

COVID-19 NEW PATIENT TELEHEALTH FORM

The completion of this form is necessary to register you with our clinic.
This service is not covered by Saskatchewan Health. Whether or not you were referred by a doctor or specialist does not change the funding/coverage.

Date:

PATIENT INFORMATION

NAME:
Last:
First:
DATE OF BIRTH:
REFERRING DOCTOR:
FAMILY DOCTOR:

FUNDING

Is this a Work Injury? (YES) or (NO)

- If yes, has the injury been reported to WCB through your employer? (YES) or (NO)
- If you have not reported the injury to your employer, please advise the front desk to provide you with a W1 form to complete.
- WCB claim Number: _____

Is this an SGIClaim (YES) or (NO)

- Sgi Claim Number:_____
- Name of Adjuster: _____

Do you have Group Insurance? (YES) or (NO)

- Do you intend to pay and submit your own receipts for reimbursement? (YES) or (NO)
- If you intend for us to bill your insurer directly, you must supply evidence that this is possible under your plan and we will work with you in billing directly.
- Not all insurers cover Telehealth

Please read the following statements and sign below.

- I must inform this office of any other practitioner (other than physicians) that I am currently seeing.
- I must inform my physical therapist of any contagious or infectious condition that I might have.
- I understand that I need to express all of my health concerns (both current and past) to my therapist.
- I understand that there is a cost to prepare copies of documents contained in my chart if requested.
- I agree to pay for all services provided as they occur, after each appointment.
- I agree to provide my contact information and will advise Bourassa & Associates of any changes as they occur. I understand that in providing my email address to you that it will be used for the purpose of communication of appointments, invoicing and announcement of services. This is for internal use only and will not be shared with any parties.

My signature below indicates my understanding of all the above information.

_____
Signature

PATIENT CONSENT

- I consent to being examined and treated via Telehealth. Although we are using all recommended levels of security, it is not possible to be absolutely certain.

- In normal times, treatment may involve the use of various physical and electrical modalities, correction of abnormal function of various body parts by the therapist mobilizing or manipulating joints and tissues, as well as exercise programs aimed at mobility, strength and function.
- During COVID-19, telehealth will consist of the usual history and health inquiry. We may ask you to perform various movements that we will observe via webcam. We will advise of appropriate self management. I understand the limitations of the compromised physical examination and associated risks that recommended management may cause increased symptoms and a limited chance of progression of the condition.
- I understand that there is a risk of soreness with recommended treatment.
- I understand there is a rare risk of advancement or worsening of conditions with recommended treatment.
- This consent has been verbally discussed with me by the assessing therapist
- I understand that I can abort this method of care at any time.
- I understand that both the patient and the therapist will disclose who is listening or watching the Telehealth interaction.

EHEALTH and PRIVATE RADIOLOGY CONSENT

- ehealth is a Saskatchewan Health site that allows access to any records of procedures or consultations done in a public facility. The clinic is a registered facility with ehealth and can access your records on a "need to know" basis.
- Private Radiology servers exist outside ehealth. The clinic is a registered facility with these servers and can access your records on a "need to know" basis.
- I consent to this clinic accessing my records on a need to know basis.

_____
Patient Signature

If the client is under 16 years of age the following section of the consent form must be completed by a Parent or Guardian before treatment can be initiated.

I have read and fully understand all of the above information and give my permission to have _____(Full name of client) assessed and/or treated at Bourassa & Associates Rehabilitation Centre and agree to be responsible for the costs.

_____
Printed Name of Parent or Guardian:

_____
Address of Parent or Guardian:

Contact information of Parent or Guardian:

Home Phone #: _____Cell Phone #: _____Work Phone #: _____

_____ _____ _____
Signature of Parent or Guardian Witness Date

ASSESSING THERAPIST ACKNOWLEDGEMENT OF INFORMED CONSENT DISCUSSION

- The above consent has been explained, line by line, to the patient and the patient was offered an opportunity to discuss any concerns.

_____ _____
Therapist Signature Therapist Name

FOR OFFICE USE ONLY

Verified and entered by:_____ Date entered:_____