Consent Form

Aurora Sports Medicine Professionals (**The Clinic**) requires your informed consent to provide assessment and treatment services to you, and to collect and use your personal information. We want you to understand the services we provide, the cost, and how we may use your personal information.

Consent For Treament

I agree to participate in assessments and treatments given by the treating provider. I understand that the provider will educate me on treatment options and I have the ability to refuse these treatments at any time.

Consent for Cost of Services

I agree to the costs of the assessment and treatment sessions. I understand they are not covered by OHIP and that payment must be made at time of treatment. I understand that if third party payers (EHC, MVA, WSIB) do not cover the charges, I am responsible for payment of services. If I wish to carry a balance with my treatment services I must provide a credit card number as security for payment.

I understand the cancellation policy of 24 hours prior notice is in effect. All regular posted fees will be applied for appointments missed or without appropriate cancellation notice and that I am responsible for payment of the full amount of those fees.

Consent to Collect and Disclose Personal Information

Personal information that **The Clinic** collects, retains, uses, and discloses may include, without limitations, your name, age, contact info, health benefit info, occupation, personal health info, medical history, and other information deemed necessary to fulfill the following purposes:

i. To provide assessment and treatment services;
ii. To comply with the requirements of professional regulatory bodies, including file audits;
iii. To invoice you directly for services provided, and to process payments for those services;
iv. To invoice Third Party Payers for services provided to you; and
v. To provide Physicians and Legal Counsel with progress reports/assessment findings, resulting from services provided to you.

I understand that **The Clinic** collects, uses, and discloses only personal information required to fulfill the purposes noted above. I understand **The Clinic** shall not use my personal information for purposes other than those noted above without my consent. I understand that I may request a copy of the Privacy Policy and that I may direct any questions about my privacy to the Privacy Officer.

I _____ , have read and understood this consent form and the terms therein.
I hereby give **The Clinic** permission and consent to maintain personal information already on file with **The Clinic**, pursuant to its Privacy Policy. I understand that my consent may be revoked in writing as outlined in **The Clinic** privacy policy.

Print Name: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____