Consent, Confidentiality + Cancellation Policy

Appointment Cancellation Policy:

At Davenport Physiotherapy, we understand your time is valuable. Our practitioners aim to run on time and your punctual attendance is appreciated. If you arrive late for your appointment your practitioner will endeavour to provide you with optimal treatment but in some situations appointments will need to be rescheduled or treatment time reduced.

We do ask that you contact us the day before should you need to reschedule or cancel your appointment. Regular cancellations/non-attendance or cancellations with less than 24h notice will incur a cancellation fee.

I acknowledge the cancellation policy above.

Signed: _____ Date: _____

Confidentiality Form:

All interactions which take place in the setting of therapy are considered confidential. This includes requests by telephone, all interactions with this therapist, any scheduling or appointment notes, all session content records and any progress notes that I take during your sessions. You may choose to give me permission in writing to release any or specific information about you to any person or agency that you designate.

Limits to this agreement

1. In some legal proceedings a judge may issue a court order.
2. If I learn of or believe that there is physical or sexual abuse or neglect of any person under 18 years of age, I must report this information immediately.
3. If I learn of or believe that an elderly person, or disabled person is being abused or neglected, I must file a report with the appropriate state agency that handles elder abuse.
4. If I learn of or believe that you are threatening serious harm to another person, I am obligated to report this. This can be in the form of telling the person who you have threatened or contacting the police.
5. If there is evidence that you are a danger to yourself and I believe that you are likely to harm yourself unless protective measures are taken, I am required to report this to the relevant authorities.
6. There may be times when I consult with outside sources about cases. In these cases, no personally identifiable information will be used to discuss this case. However, discussion topics will be used in order to ensure that I am getting and giving the best assistance possible. The persons with whom I discuss cases are legally bound to keep information confidential.

Patient's name: _____
Patient's signature: _____
Guardian (If required): _____
Date :_____

Consent Form

Dear NDIS Participant:

Physiotherapy involves many different types of physical evaluation and treatment. As with all forms of medical treatment, there are benefits and risks involved with physiotherapy. The physical response to treatment varies and cannot always be predicted as every individual is different. There is no guarantee that the treatment will help

the condition you are seeking treatment for and there is a risk that treatment will cause some discomfort or aggravation of the existing condition.

During your physiotherapy visit, it is often necessary to expose and touch the area in need of treatment. At times, the practitioners may ask you to remove some items of clothing in order to facilitate treatment. If you do not feel comfortable with any part of the treatment, please tell us immediately. Every effort is made to preserve modesty and keep you comfortable. Please communicate to your therapist and the operations manager if you have any other concerns during the treatment.

By signing this, I hereby consent to the rendering of a physiotherapy evaluation and treatment as deemed appropriate by the treating therapist. I have the right to decline treatment at any time. The therapist will explain your physiotherapy diagnosis and discuss treatment recommendations with you. Physiotherapy, as with any type of medical care, is the most effective if you participate according to the treatment plan agreed upon with your therapist. If at any time you have questions regarding treatment and services provided, please do not hesitate to talk to your therapist.

o I authorize the release of all necessary information to my primary care provider and/or referring physician.
o I authorize the release of information to Davenport Physiotherapy in regards to my care and/or status.
o I have read this form and agree to all consent regarding physical therapy evaluation and treatment.

Patient's name: _____
Patient's signature: _____
Guardian (If required): _____
Date :_____