## Kinesiology Services Informed Consent For Assessment, Treatment, Fees and The Collection, Use & Disclosure of Personal Information

It is necessary for you the client to give your informed consent to receive kinesiology assessment & treatment services, accept the costs involved and for the collection, use and release of your personal information. I(We) want you to understand the services provided, the costs involved and what happens with the personal information obtained or created about you by us.

### **Consent for Assessment & Treatment**

Kinesiology may involve the use of a variety of physical fitness evaluation and treatment techniques along with various procedures and modalities used to assist in improving your health and functional ability. As with all forms of medical treatment, there are benefits and risks involved with this type of treatment. Since the physical response to a specific treatment can vary widely from person to person, it is not always possible to accurately predict your response to any given component or procedure. We are not able to guarantee precisely what your reaction to a particular treatment might be, nor can we guarantee that our treatment will help the condition you are seeking treatment for. There is also a risk that your treatment may cause pain or injury, or may aggravate previously existing conditions. You will be informed of (and have the right to ask) what type of treatment is being planned based on your history, diagnosis, symptoms and assessment findings. You may also request additional detail regarding the potential risks and benefits of a specific treatment might be if the initial explanation is unclear to you at any time. You have the right to decline any portion of your treatment at any time before or during your treatment sessions. Therapeutic exercises are an integral part of most treatment plans. Exercise has inherent physical risks associated with it. If you have any questions regarding any part of your treatment, including any exercise and the possible risks or side effects that may be associated, it is important you advise the kinesiologist of your concerns at the earliest opportunity.

#### **Consent for Service Costs**

Please ask to see the fee schedule if you are unable to see it. The schedule details the fees for individual appointment sessions, assessment, reports and the cost to obtain copies of your records should you wish to do so. The fees charged are typically based on time but can vary depending on they the type of treatment or assessment you are receiving and whether or not treatment is delivered on site (clinic location) or off site (at your home or other location). If no insurance company or other third party payer agrees to cover the services provided, you are responsible for paying the full amount of those services at the time service is rendered.

#### Consent for the Collection, Generation and Disclose of Personal Information

Pursuant to the Personal Information Protection Act of BC (PIPA-BC) I am (We are) responsible for the security and privacy of your personal information under my (our) control. A Corporate Privacy Policy is in place and details what information is maintained, how long it is maintained, how the information is secured and how the information is disposed of. If you would like to review the complete "Corporate Privacy Policy" to obtain additional details on the collection, generation, use, release and disposal of your personal information, you may request to view a copy and one will be provided to you.

| Page 1 of 2  | Client Initials |
|--------------|-----------------|
| 1 420 1 01 2 | Chefit initials |

# <u>Informed Consent for Assessment, Collection, Use & Disclosure of Personal Information</u>

I have read and understand the information contained herein and hereby provide my informed consent to being assessed and afford the kinesiologist and their agents, past, present and future the right to collect use & disclose my personal information for the purposes I have indicated below:

| 1.   |  | ranformation including reports to any third-part  | y funding all or par   | t or my   |
|--|--|---|--|---|
|  |  | Safe BC, Extended Benefits Company, other)  |  | ПМ  |
|  | a. Treatment Reports O   | •   | □ Yes  | □ No  |
|  | -  | nd other treatment related information  | □ Yes  | □ No  |
| 2.   | Disclose medical or other info   | • •   | ☐ Yes  | □ No  |
| 3.   | Disclose medical information   |   |  |   |
|  | other therapists who are part of   | of my treatment team for the purpose of providi   | ng best-practices tr   | eatment   |
|  | services.  |   | ☐ Yes  | □ No  |
| wri  | •  | ay be amended or revoked in whole or in part as outlined in the Corporate Privacy Policy  Signature   | y.<br>   | rate  |
| I dec  | ,  | ent named herein and I hereby give permission and consent we indicated above.   |  |   |
| Guardian Name  |  | Signature   | D  | ate   |
| I furthey kind and treathat that agrees agrees pressures that the treathat that agrees agrees pressures pressures pressures agrees pressures press | y are recommending based on resiologist has also explained to answered any questions I have attended are and what alternate trait is my responsibility to follow mended treatment and I here ee to proceed with treatment, a | wing being assessed, the kinesiologist has explainly medical history, diagnosis, symptoms and as me what the potential risks and benefits of the c. The kinesiologist has indicated what the risks eatments may be available to me that are known with the kinesiologist or my physician if I beby acknowledge that I accept any and all inhering that I have been provided details of the treatments if there is no third-party funding those costs. | ssessment findings. treatment recomme s of having and not in by the kinesiological have any concernstent physical risks of ment costs and that | The ended might be having ist. I understand over the of injury and I am |
| Pa   | tient Name   | Signature   |  | ate   |
| O  | R IF THE CLIENT IS A MINOR (U  | UNDER 19 YEARS OF AGE AT DATE OF SIGNING)   | OR OTHERWISE NO  | T COMPETENT   |
|  |  | ent named herein and I hereby give permission and consent cated above and that I will accept responsibility for ensuring  |  |   |
| Gu   | ardian Name  | Signature   | D  | ate   |
|  |  |   |  |   |

Page 2 of 2

Client Initials\_\_\_\_\_