30 York St. Dundas, ON L9H 1L2
Phone: 905-628-5518
Fax: 905-628-5744

Highland PHYSIO DUNDAS est. 2000

Toll Free: 1-877-863-9069
Email: highlandphysio@cogeco.net
Website: www.highlandphysio.ca

HIGHLAND PHYSIO INC.
PRIVACY POLICY INFORMATION FOR PATIENT

Privacy of personal information is important to Highland Physio. We will collect, use and disclose personal information responsibly, and only the extent necessary for the services we provide. We also try to be open as to how we handle your information.

WHAT IS PERSONAL INFORMATION?
Personal information is information that allows someone to identify an individual. This includes information that relates to their personal characteristics (age, income, address or phone number) their health, or their activities and views (opinions expressed, or evaluation of an individual). This is not the same as business information, which is not protected by privacy legislations.

WHO WE ARE
Highland Physio is made up of Physiotherapists, Kinesiologists, Massage Therapists, and support staff. We use a number of consultants and agencies, that may, in the course of their duties, have limited access to personal information we have. These include bookkeepers and accountants, temporary workers to cover holidays, credit card companies, insurance companies, cleaners and lawyers. We restrict their access to any personal information we have obtained as much as is reasonably possible. We also have signed confidentiality agreements that they will follow appropriate privacy principles.

WHY WE COLLECT PERSONAL INFORMATION
Like all rehabilitation professionals, we collect, use and disclose personal information in order to serve our clients. The main purpose for collecting this information is to provide rehabilitation treatment. We collect information about health history, physical condition, function and social situation in order to help us assess their health needs are, to advise them of their options and then to provide the health care they choose to have. A second reason is to obtain a baseline of health and social information so that in providing ongoing health services, we can identify changes that are occurring over time. It would be rare for us to collect such information without the express consent of the patient, but this might occur in an emergency, or where we believe the patient would consent if asked and it is impractical to get consent.

RELATED REASONS FOR COLLECTING PERSONAL INFORMATION
The most common examples of using personal information for non-treatment purposes are as follows:

- To invoice clients for services that was not paid for, to process credit cards, or to collect unpaid accounts.
- Our clinic reviews client and other files for the purpose that we provide high quality services, including the assessment of staff performance. External consultants may, on our behalf perform audits and continuing quality reviews of our clinics, including reviewing client files and interviewing our staff.
- Physiotherapists and other professional staff are regulated by their respective colleges, who may inspect our records and interview our staff as part of their regulatory activities. As professionals, we will report serious misconduct, incompetence or incapacity of other practitioners, whether they belong to other organizations or our own. The company believes that it should report information suggesting illegal activities to the authorities. External regulators have their own strict privacy obligations. Various government agencies have the authority to review our files and interview our staff as a part of their mandates. In these cases, we may consult with lawyers or accountants before releasing information.
- Most of our goods and services are paid, either in whole or in part, by third parties (e.g., WSIB, private of auto insurance). These payers often have your consent or legal authority to direct us to collect and disclose to them certain information in order to demonstrate client entitlement to this funding.
- Upon discharge, charts are kept for a minimum of ten years, massage therapy is ten years. This allows us to answer questions about treatment received in the past.
- In the unlikely event that The Company or its assets were to be sold, the buyer would want to conduct “due diligence”, to ensure that this is a viable business. This may involve review of accounting/service files. None of

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that information would be recorded, and the buyer would need to sign a written promise to keep all personal information confidential.

PROTECTION OF PERSONAL INFORMATION

Because we understand the importance of protecting personal information, we have undertaken to:

- Supervise or secure paper information in a locked or restricted area.
- Secure electronic hardware in a locked or restricted area. Computers are password protected. Our cell phones are digital, which is harder to intercept.
- Transmit paper information through sealed addressed envelopes or boxes labelled "Private and Confidential" by reputable couriers.
- Transmit electronic information either through a direct line or is anonymized or encrypted.
- Train our staff to collect, use and disclose personal information only as necessary to fulfill their duties.
- External consultants and agencies with access to personal information must enter into privacy agreements with us.

RETENTION AND DESTRUCTION OF PERSONAL INFORMATION

We keep our clients' paper files for at least ten years; massage therapy is ten years, after which time they are systematically destroyed by shredding. Electronic information is deleted, and when the hardware is discarded, we ensure that the hard drive is physically destroyed.

YOU CAN LOOK AT YOUR INFORMATION

With some exceptions, you have the right to view your files and personal information. Often all you need to do is ask. We will help you identify which records you need, or would like to view. We will help you to understand what is written, by providing a professional to review the file with you at an appointed time.
We will ask you to put your request in writing. As well, there may be a fee charged to allow for the professional's time. If your information is more than one year old, then there will be an additional fee to retrieve it from storage.

If we are unable to provide access, we will tell you within 30 days, as well as, as best we can, why we are unable to provide access.

If you believe that there is a mistake in the information, you have the right to ask it to be corrected. This applies to facts only, and not to any professional opinions. We will ask you to provide documentation that our files are wrong. Where we agree that we made a mistake we will make the correction and notify any involved third party. If we do not agree that there has been an error, we will include in our file a brief statement from you regarding the mistake and forward it to any involved third party.

DO YOU HAVE A QUESTION?

Our Information Officers, Rob McCall and Paul Jager, can be reached at:

Highland Physio Inc.
30 York Street
Dundas, ON, L9H 1L2

905-628-5518
highlandphysio@cogeco.net

We will attempt to answer any questions you may have. If you have a formal complaint about our privacy policy, you may make it in writing to our Information Officers. We will acknowledge receipt of your complaint and make certain that it is investigated promptly, and you will be provided with a written response.

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Questions or concerns about the competency of our staff may be directed to the Information Officers. If we cannot satisfy your concerns, you are entitled to complain to the appropriate regulatory body, as defined by the Regulated Health Professions Act (e.g.: The College of Physiotherapists of Ontario, The College of Massage Therapists of Ontario, etc).

This policy is made under the Personal Information Protection and Electronic Documents Act. This is a Complex Act and provides some additional exceptions to the privacy principles outlined above. There are some rare exceptions to the commitments set out above.

For more general inquiries, you may contact the Information and Privacy Commissioner of Canada. He can be reached at:

112 Kent Street
Ottawa, ON, K1A 1H3
Phone 613-995-8210/ Toll Free 800-282-1376/ Fax 613-947-6850/ TTY 613-992-9190
www.privcom.gc.ca

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Demographics

First Name: _____ Preferred Name: _____ Last Name: _____

Date of Birth (MMDDYY): _____ Weight/Height/Foot Size: _____/_____/_____

Address: _____ City: _____ Province: _____

Postal Code: _____ Sex: Male ☐ Female ☐ Other ☐ (please describe) _____

Home Phone: _____ Cell: _____ Work: _____

Email: _____ Employer: _____ Occupation: _____

Family Physician: _____ Referral Source: _____

ONLY IF WSIB: OHIP # _____ SIN _____

Medical/Surgical History

Please check if you have ever had any of the following. Please give appropriate date of onset if applicable.

✓	Condition	Date	✓	Condition	Date	✓	Condition	Date
	Heart Trouble			Arthritis			Depression/Anxiety	
	High Blood Pressure			Diabetes			Osteoporosis	
	Bleeding Disorder			Fracture			Thyroid Problems	
	Epilepsy			Cancer			WSIB Injuries	
	Stroke			MVA Injury			Lung Problems	
	Sleep Disorder			Infectious Disease			Nervous Disorders	
	Back Injury			Stomach Ulcers			Pacemaker	
	Allergies			Head Injury			Prostrate/Pelvic	

✓	Symptom	✓	Symptom	✓	Symptom	✓	Symptom
	Joint pain or swelling		Weakness in arms/legs		Shortness of breath		Vision problems
	Difficulty walking		Pain at night		Headaches		Loss of balance
	Dizziness/blackouts		Difficulty sleeping		Chest pain		Bowel/bladder problems
	Weight loss or gain		Hearing problems				

Have you ever had surgery? ☐ Yes ☐ No Please describe, and include dates (month, year):

Please list any medications you are currently taking (including Advil, Tylenol, ibuprofen, etc.):

Signature: _____ Date: _____

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Highland Physio Inc.

Medical Information Release Form

I, _____, hereby give permission to Highland Physio Inc. to contact and share or receive health information with my family physician, or any other health professional to determine my progress/and or confirm details of the Auto Insurance payment schedule.

Signature _____ Date _____

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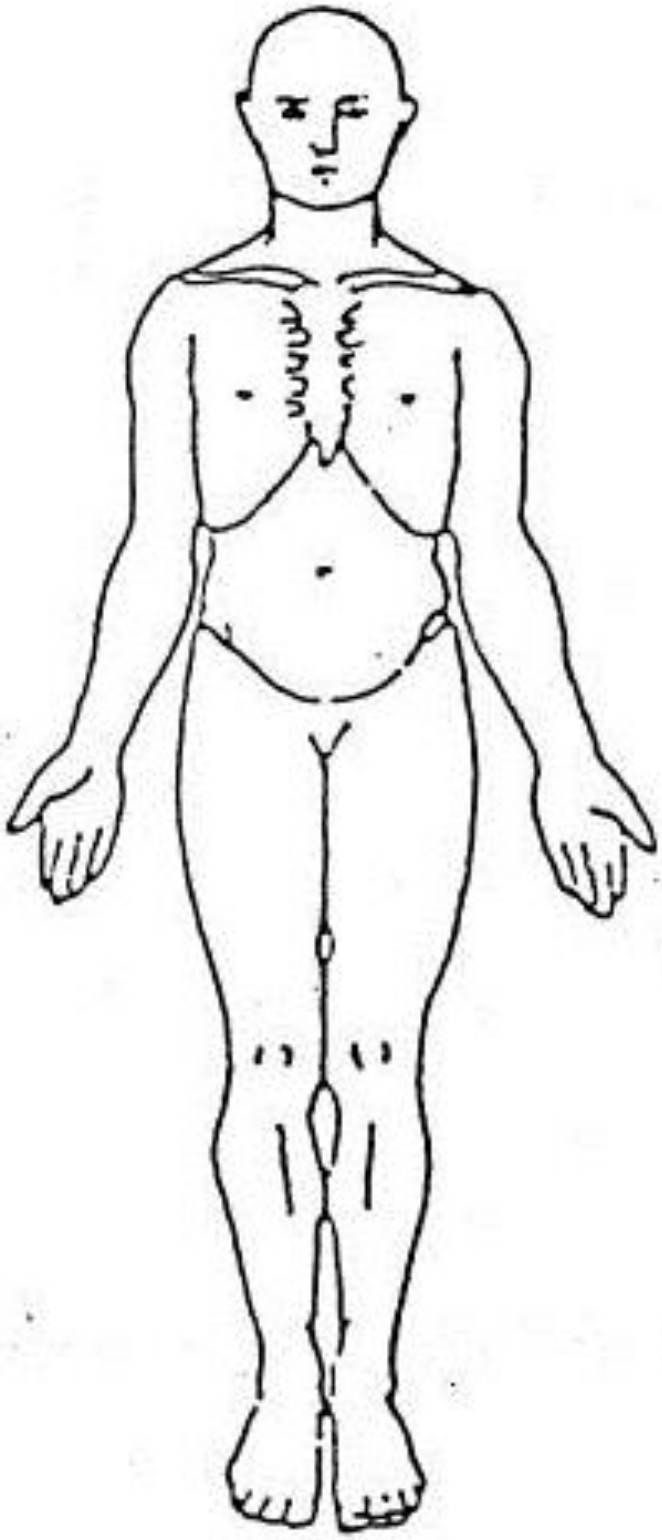
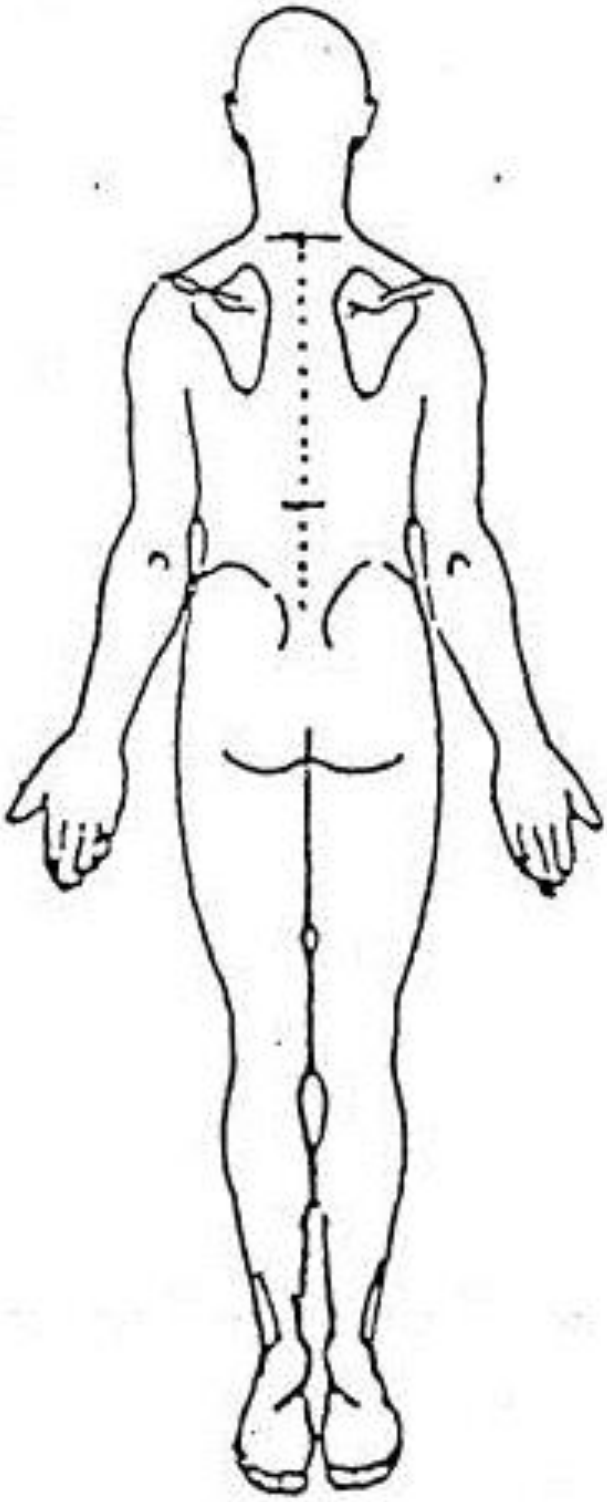
Please shade the areas on the diagram where you are experiencing pain.





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P4 PAIN INTENSITY MEASURE

When answering these questions, think only of the pain you are experiencing in relation to the problem for which you are having treatment.

Circle one number for each of the four questions.

On average, how bad has your pain been:

0 = No Pain 10 = Pain as bad as it can be

In the morning over the past 2 days?	0	1	2	3	4	5	6	7	8	9	10
In the afternoon over the past 2 days?	0	1	2	3	4	5	6	7	8	9	10
In the evening over the past 2 days?	0	1	2	3	4	5	6	7	8	9	10
With activity over the past 2 days?	0	1	2	3	4	5	6	7	8	9	10

Signature: _____ Date: _____

COVID-19 Screening

Please fill out quick survey prior to your visit to help everyone stay safe and healthy.

Name: _____ Date: _____

1. Have you travelled outside of Canada in the past 14 days? Yes ◯ No ◯
2. Have you tested positive for COVID-19 or had close contact with a confirmed case of COVID-19 without wearing appropriate PPE? Yes ◯ No ◯
3. Do you have any of the following symptoms?

- ☐ Decrease/loss of sense of taste or smell
- ☐ Worsening chronic cough
- ☐ Difficulty breathing
- ☐ Difficulty swallowing
- ☐ Runny nose/nasal congestion with no known cause
- ☐ Unexplained fatigue/malaise/muscle aches
- ☐ Nausea/vomiting, diarrhea, abdominal pain
- ☐ New onset of cough
- ☐ Shortness of breath
- ☐ Sore throat
- ☐ Headache
- ☐ Pink eye
- ☐ Chills
- ☐ Fever

4. If you are 70 years of age or older, do you have any of the following symptoms?

- ☐ Delirium
- ☐ Unexplained or increased number of falls
- ☐ Acute functional decline
- ☐ Worsening of chronic conditions

- ❖ If you have answered **NO** to all questions and do not exhibit any of the listed symptoms, then you may proceed with your appointment.
- ❖ If you have answered **YES** to any questions or any symptom then you may be asked to reschedule your appointment and further questioning may be required.

Signature: _____

By signing above, I certify all information is true and correct to the best of my knowledge.

THANK YOU

HIGHLAND PHYSIOTHERAPY

HEALTH CONSENT FORM (Physiotherapy)

We need your informed consent. This means that we need you to understand the services we provide, the costs, and what we do with the personal information we gather about you. Please ask us if you have any questions.

CONSENT FOR THE COLLECTION OF PERSONAL INFORMATION

I understand that to provide me with physiotherapy or massage therapy and services, Highland Physiotherapy (herein known as the company) will collect some personal information about me. (e.g., name, address, phone numbers, and health history).

I have had the opportunity to review The Company's Privacy Policy about the collection, use, and disclosure of personal information, steps taken to protect the information and my right to review my personal information. I understand how the privacy policy applies to me. I have been given a chance to ask questions I have about the privacy policies and they have been answered to my satisfaction.

I understand that, as explained in the Policies and Procedures for Personal Information, there are some rare exceptions to these commitments.

I agree to The Company collecting, using, and disclosing personal information about me as set out above and in The Company's Privacy Policy.

FEE SCHEDULE

Physiotherapy treatments in our clinic are NOT COVERED BY OHIP. Extended Health Insurance coverage for physiotherapy is provided by various companies and we advise you to determine if you have such coverage (we will be happy to provide you with invoices so you can submit to your insurance company). If you are seeking physiotherapy treatment as a result of a W.S.I.B. claim, or Motor Vehicle Accident, please advise us of such and we will initiate the appropriate billing.

However, please be advised that our contract is with you, the patient, and therefore you are ultimately responsible for payment of treatments rendered. This applies to all coverage methods (ie. Extended Health Care, W.S.I.B, and Motor Vehicle Insurance etc…). Please feel free to direct your questions to our staff. We will make every effort to assist you with your claim.

We accept Visa, MasterCard, American Express, Interac, Cheque or Cash.

PHYSIO ASSESSMENT	**$90.00**
SUBSEQUENT PHYSIO TREATMENTS	**$70.00**
***VESTIBULAR ASSESSMENT**	**$90.00**
SUBSEQUENT VESTIBULAR TREATMENT	**$70.00**
NO SHOW APPOINTMENTS	**$70.00**
SHORT NOTICE CANCELLATIONS	**$40.00**
CANCELLED APPOINTMENTS (with 24 HOUR NOTICE)	**N/C**

*** Vestibular refers to patients with dizziness, vertigo, and imbalance.**

See other side

INFORMED CONSENT TO PHYSIOTHERAPY TREATMENT AND CARE

In April, 1995, the Ontario Government passed the Consent to Treatment Act to safeguard the rights of people to make their own informed decisions about health treatment. The legislation requires that our therapists provide you with the necessary information on the treatment proposed so that you can make an informed choice. The purpose of this document is to outline what is involved in our physiotherapy treatment.

Depending on your needs, your program may consist of any of all of the following:

- Therapeutic exercise to restore strength and range of motion
- Electrical modalities to decrease pain and inflammation, and to promote healing
- Hands-on manual techniques to restore functional mobility and reduce pain
- Progressive strengthening and aerobic exercise to restore and maintain normal muscle strength and endurance.

Your treatment program will be designed and monitored by your physiotherapist. A Kinesiologist and/or Physiotherapist Assistant may also provide assistance in your daily care.

As in all health care, in the practice of physiotherapy, there are some risks associated with treatment, although rare. They include, but are not limited to muscle strains and sprains, fractured bones, and burns from electrical modalities.

The program is tailored to your specific stage of recovery. You may find that you are a little more stiff and sore after an initial assessment. This is because the physiotherapist must put your body through some movements that you may not normally do in order to determine the nature of the problem. Please keep the physiotherapist informed about changes in your symptoms during the course of treatment so that they can respond accordingly. We ask that you follow the therapist's instructions so that you perform the activities in a safe manner to avoid any risk of injury.

You may discontinue the treatment at any time, but we ask that you extend the courtesy of informing one of our staff of your intention to discontinue and your reasons for doing so.

If you have any further questions, you are encouraged to ask our therapists.

I have been informed of the treatment outlined above and its possible risks. I voluntarily give consent to participate in the rehabilitation program and realize that I may, at my discretion, discontinue treatment at any time. **I also understand that 24 hours notice of cancellation is expected in order to avoid billing my personal account.** By signing below, I intend this consent form to cover the entire course of treatment for my present condition.

_____ _____

Signature Date

_____ _____

Printed Name Witness

Notes: