Workplace Safety and Insurance Board – Client Information and Consent Form

If you have been hurt at work and plan on billing WSIB, **you must have an approved claim number to receive coverage**. It is your responsibility to ensure that WSIB receives all of the necessary paperwork (from you, your work and your doctor) so that we may receive timely payment from WSIB.

If your claim is pending, a 10-day grace period will be provided to allow time for your claim to be processed. After this period, if your claim has not been approved, you be responsible for paying for the assessment and treatments to date. At that time, you have the option to put treatment on hold until your claim has been approved or continue to pay out of pocket for subsequent visits. Invoices will be provided to you per visit. You may decide to submit the invoices to your extended health benefits (should you have them.) If the claim is later approved, we will reimburse you immediately after receiving the payment from WSIB.

Please provide us with the following information of your WSIB information:

Claim #:__________________ SIN#:___________________ Accident date:___________________________

Name & address of workplace:____

Workplace contact person:_________________________ Ph#:___________________________________

Fax #:___________________________ Number of years working at current employer:________

Cancellation Policy:
You will be billed for missed appointments unless 24 hours advanced notice of cancellation is received. In the event that cancellation is not received in a timely fashion, a fee of $60 will be charged to your account. WSIB will not cover cancellation fees.

Please provide us with the following information of your extended health benefit coverage (if applicable):

Name of Ins. Company ____________________ Policy/Plan #_________________________

ID#____________________________________ Dollar Limit:__________________________

Percentage coverage:_____________________

I hereby assume responsibility of payments should my claim be rejected. I understand that the services rendered will be at the regular cost of $60/visit and $85 for the initial assessment/consultation.

I agree that I will pay for any missed or cancelled appointments at a fee of $60/incident should they occur (as WSIB will not pay the fee for my missed or cancelled appointments.) I agree that in the event a cancellation fee is charged to my account, I will pay these charges within 1 week of the occurrence. This cancellation fee provides compensation for both the therapist's time and in fairness to other clients who could have otherwise been able to book an appointment at your scheduled time.

I have read and understood all of the above statements and agree to adhere to them accordingly. I give consent to be assessed by the staff at Impact Physiotherapy.

Client's Name (Print): __________________ Client's Signature: ___________________

Date: ________________ Witness: __________________