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.

 Client Initials_______

Informed Consent for Assessment, Collection, Use & Disclosure of Personal Information

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. Disclose medical and/or other information including reports to any third-party funding all or part of my treatment costs (ICBC, WorkSafe BC, Extended Benefits Company, other)
   a. Treatment Reports Only ☐ Yes ☐ No
   b. Treatment Reports and other treatment related information ☐ Yes ☐ No
2. Disclose medical or other information to my Lawyer ☐ Yes ☐ No
3. Disclose medical information to and obtain medical information from my Physician, treating Specialists or other therapists who are part of my treatment team for the purpose of providing best-practices treatment services. ☐ Yes ☐ No

I understand that my consent may be amended or revoked in whole or in part at any time by providing written notice to the kinesiologist as outlined in the Corporate Privacy Policy.

Patient Name ____________ Signature ____________ Date ____________

OR IF THE CLIENT IS A MINOR (UNDER 19 YEARS OF AGE AT DATE OF SIGNING) OR OTHERWISE NOT COMPETENT

I declare, I am the legal guardian of the client named herein and I hereby give permission and consent to assess the client and maintain, create or disclose client personal information as I have indicated above.

Guardian Name ____________ Signature ____________ Date ____________

Consent for Treatment & Treatment relates Fees

I further acknowledge that following being assessed, the kinesiologist has explained to me what type of treatment they are recommending based on my medical history, diagnosis, symptoms and assessment findings. The kinesiologist has also explained to me what the potential risks and benefits of the treatment recommended might be and answered any questions I have. The kinesiologist has indicated what the risks of having and not having treatment are and what alternate treatments may be available to me that are known by the kinesiologist. I understand that it is my responsibility to follow up with the kinesiologist or my physician if I have any concerns over the recommended treatment and I hereby acknowledge that I accept any and all inherent physical risks of injury and agree to proceed with treatment, and that I have been provided details of the treatment costs and that I am responsible for payment of those costs if there is no third-party funding those costs or the third-party declines to, or does not pay the costs within three (3) months of treatment.

Patient Name ____________ Signature ____________ Date ____________

OR IF THE CLIENT IS A MINOR (UNDER 19 YEARS OF AGE AT DATE OF SIGNING) OR OTHERWISE NOT COMPETENT

I declare, I am the legal guardian of the client named herein and I hereby give permission and consent to assess the client and maintain, create or disclose client personal information as indicated above and that I will accept responsibility for ensuring payment for all delivered services.

Guardian Name ____________ Signature ____________ Date ____________

Client Initials______

Kinesiology/ Soft Tissue Release Therapy/ Functional Training Intake Form

Lauren Allen. R. Kin, BA- Sports, Health, & Physical Education, STR

Patient Name: **Legal Guardian:**

Street Address:

City: **Postal Code:**

Phone: (home) **(work)**

Email Address:

Occupation:

Gender: (circle one) **Date of Birth:**

___M______F___ **________/________/________**

(Identify as:____________)

Family Physician:______________________

Phone:__________________ **Clinic:______________________**

Emergency Contact:________________________

Phone:__________________ **Relationship:________________**

Who were you referred by?:

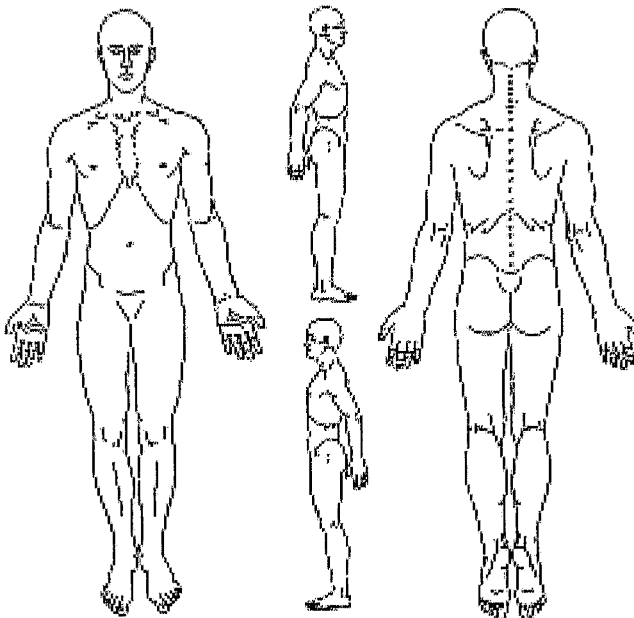
Kinesiology/ Soft Tissue Release Therapy/ Functional Training Intake Form

Lauren Allen. R. Kin, BA- Sports, Health, & Physical Education, STR

Please list all areas of concern:

1. ____
2. ____
3. ____
4. ____

Please place an "X" mark on diagram for all areas of concern:



Have you ever experienced any of the following? (please elaborate):

A hard fall?____
A car accident?____
A concussion?____
A surgery?____

Kinesiology/ Soft Tissue Release Therapy/ Functional Training Intake Form

Lauren Allen. R. Kin, BA- Sports, Health, & Physical Education, STR

Do you suffer from any pain currently and/or in the past? (please check all):

☐ hands	☐ arms	☐ knees	☐ mid back
☐ wrist	☐ sacroiliac (SI) joint	☐ feet	☐ upper back
☐ elbows	☐ Pelvis	☐ sacrum	☐ neck
☐ shoulders	☐ legs	☐ low back	☐ head

If any of these were due to a current and/or past injury, please specify:

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____

Are you currently experiencing any of the following symptoms?:

☐ dizziness ☐ vertigo ☐ speech issues ☐ difficulty swallowing

☐ weakness ☐ vision disturbance ☐ trouble with balance/coordination

☐ fainting ☐ pins and needles in specific body areas

Have you noticed any digestive symptoms? (constipation, diarrhea, ect.)

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Have you noticed any respiratory symptoms? (cough, chest pain, difficulty breathing, ect.)

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