WCB Information Sheet

For Patients

Workers Name: _____

Date of Incident: _____

(dd/mm/yyyy format)

First Doctor Seen: _____

Are you off work due to Injury: ☐ **Yes** ☐ **No**

If No: ☐ **Modified Duties** ☐ **Modified Hours**

☐ **Regular Duties** ☐ **Regular Hours**

Employer: _____

Job Title: _____

Job Duties: _____

Supervisors Name: _____

Work Phone Number: _____

Work Address: _____

WCB Admission Form

Your Responsibilities:

1. You must ensure the following forms have been received by WCB otherwise WCB will not accept financial responsibilities for physiotherapy:
    a. Employee's Report
    b. Employer's Report
    c. Physician's Report
    d. Physical Therapist's Report

    Assignment of a WCB claim number, or acceptance of a claim does not automatically mean WCB will accept financial responsibility of physical therapy treatments.

2. You must see your referring physician every 4 weeks and a report should be sent to WCB after each follow-up visit.
3. You are responsible for the cost of physiotherapy treatment at any time WCB refuses responsibility.

    Should you decide to appeal the decision of the WCB; you will be Invoiced for treatment costs as above. If the WCB should change their decision the clinic will reimburse you once the clinic has received payment.

    You can contact WCB to verify your claim status at 1-403-498-3800 or toll-free dial 310-0000 and ask for 498-3800, or you may call the Calgary office at 517-6000.

4. Arrive for your appointments in a timely fashion or notify your physiotherapist ahead of time if you're going to be late.
5. Call at least 12 hours ahead of time to cancel or reschedule appointments.
6. Bring loose fitting and comfortable clothes including proper footwear to work out in.
7. A desire to return to a job or occupation.

We ask that you sign the space below in understanding of your responsibilities and liability of any costs incurred by you at this clinic should WCB deny responsibility for your physiotherapy treatment.

_____ _____

Patient's Signature Date (dd/mm/yyyy format)

_____ _____

Witness Signature Date (dd/mm/yyyy format)

WCB Patient Rights Agreement

Responsibilities to you the Client:

1. A safe, clean environment for your rehabilitation.
2. We shall respect your dignity, needs, wishes and values.
3. We may not refuse care to you based on grounds of race, religion, ethnic or national origin, age, sex, sexual orientation, social or health status.
4. We will respect your right to be informed about the effects of treatment and inherent risks.
5. We will give you the opportunity to consent to or decline treatment or alterations in the treatment regime.
6. We will assume full responsibility for all the care we provide.
7. We will not treat you when the medical diagnosis or clinical condition indicates that the commencement or continuation of physiotherapy is not warranted or is contraindicated.
8. We shall respect all your information as confidential. Such information shall not be communicated to any person without your consent except when required by law.
9. We shall request consultation with, or refer clients to, colleagues or members of other health professions when, in the opinion of the physiotherapist, such action is in your best interest.
10. Your physiotherapist, with your or your surrogate's consent, may delegate specific aspects of your care to a person deemed by your physiotherapist to be competent to carry out the care safely and effectively.
11. Your physiotherapist is responsible for all duties they delegate to personnel under their supervision.

If at any time you feel your rights have been violated discuss it with your therapist. If you are uncomfortable doing so, ask any staff member to see the clinic director. Within 24-hour period your concern will be addressed.

The undersigned affirms that I have read, asked about, and received satisfactory explanation of any part of this document that I did not understand.

_____ _____

Patient's Signature **Date** (dd/mm/yyyy format)