CONSENT FORM

I, the undersigned, voluntarily consent to the procedures and treatments provided to me at Lantzville Wellness Centre.

- I acknowledge and accept that there may be risks associated with these procedures and treatments, and that the risks will be explained to me in a manner that I can understand prior to any treatment. With this knowledge, I understand and acknowledge that I may ask questions regarding my treatment at any time and that I am free to withdraw my consent and discontinue participation in any procedures or treatments at any time. I further understand and acknowledge that no guarantees have been given to me by Lantzville Wellness Centre or any of its practitioners or personnel regarding cure or improvement of my condition.

- I hereby consent to the collection, use and/or disclosure of my personal information for purposes related to the delivery of patient care and other related uses at Lantzville Wellness Centre. I understand that a record will be kept of the health services provided to me. I further understand that my personal information including this record will be kept confidential and will not be released to others unless so directed by me or my representative or otherwise permitted or required by law.

- I hereby acknowledge and agree that I am financially responsible for all payments owing for services received at Lantzville Wellness Centre. I understand and agree that payment must be made at the time services are rendered and/or at the time products are purchased. **Additionally, I am aware of the clinic's policy for a missed or cancelled appointment and agree to pay the charge of the treatment should I miss, cancel, or wish to change a previously scheduled appointment without providing a minimum of 24 hours notice.**

ELECTRONIC TRANSMISSION AUTHORIZATION AND CONSENT

- I authorize my healthcare provider to collect, use and disclose personal information concerning any claims submitted on my behalf with the insurer and/ or plan administrator and their service provider(s) for the purposes of assessing your claims, underwriting, investigation, auditing and administering the group benefits plan, including the investigation of fraud and/ or plan abuse. I understand that personal information may be subject to disclosure to those authorized under applicable law. I agree that a photocopy or electronic version of this authorization shall be as valid as the original and may remain in effect for the continued administration of the group benefits plan.

- I confirm that I am authorized by my spouse and/ or dependents, if any, to disclose personal information about them to the insurer and/ or plan administrator and their service provider(s) for the purposes described above and I confirm that my spouse and/ or dependents also authorize the insurer and/ or plan administrator and their service provider(s) to disclose information about their claims to me, for the purposed of assessing and paying a benefit, if any, and managing the group benefits plan. I also authorize my spouse and/ or dependents to assign benefit payment under the plan to the healthcare provider. This also applies to **emailing** your case manager for WSBC patients.

- In the event there is suspicion and/ or evidence and/ or fraud and/ or plan abuse concerning claims submitted, I acknowledge and agree that the insurer and/ or plan administrator and their service provider(s) may use and disclose relevant personal information to any relevant organization including law enforcement bodies, regulatory bodies, government organizations, medical suppliers and other insurers, and where applicable my Plan Sponsor, for the purposes of investigation and prevention of fraud and/or plan abuse.

If there is an overpayment, I authorize the recovery of the full amount of the overpayment from any amount payable under the group benefits plan, and the exchange of personal information with other persons or organizations, including credit agencies and where applicable, my Plan Sponsor, for that purpose.

Patient Name:_____ Patient Signature:_____

Therapist Name:_____ Therapist Signature:_____

Date: _____