Worker's Compensation Board (only if this injury occurred at work) I will provide the physiotherapy office with my claim number from WCB as soon as possible to ensure the treatment costs will be covered. If, however, the claim is denied, the cost of treatment is my responsibility and I agree to pay the facility all the fees incurred.

_____	_____	_____
Patient Name	Patient Signature (Guardian)	Date
_____	_____	_____
Physiotherapist Name	Physiotherapist Signature	Date