

Annual Block Fee Plan <u>INCLUDES</u> the following services:	If you <u>DO NOT</u> enroll in the Annual Block Fee Plan, you will be required to pay the following fees:
Daycare Note	\$25.00
Disability Tax Credit	\$50.00
Doctor Note	\$25.00
Dressing Change	\$25.00
Employment Insurance/Maternity Certificate	From \$25.00
Faxing and Photocopying (per page)	\$1.50
Forms for Fitness Clubs	\$40.00
Ministry of Transportation Medical Exam (visit & forms)	\$175.00
Missed Physical appointment without 24 hours notice (max 1/year)	\$75.00
Missed Routine appointment without 24 hours notice (max 1/year)	\$45.00
Other Forms not covered by OHIP (50% discount with annual fee)	From \$25.00
Pre-Employment Certification of Fitness (Form Only)	\$35.00
Referral Notes for Chiropody or Orthotics*	\$25.00
Referral Notes for Chiropractors*	\$25.00
Referral Notes for Massage Therapy*	\$25.00
Referral Notes for Physiotherapy*	\$25.00
Skin Lesion Removal up to 5 by Liquid Nitrogen <ul style="list-style-type: none"> • Skin tag, wart treatment, seborrheic keratosis 	\$35.00
Skin Lesion Removal 5 or more by Liquid Nitrogen <ul style="list-style-type: none"> • Skin tag, wart treatment, seborrheic keratosis 	\$55.00
Replacement of Lost Immunization Record	\$25.00
Report for Citizenship and Immigration	\$120.00
TB skin test – 1 step test	\$55.00
TB skin test – 2 step test	\$95.00
Telephone Prescription Renewal (max 1/yr)	\$25.00
Travel Cancellation Forms	\$40.00
Transfer of Medical Records at the patient's request (first 5 pages)	\$40.00
Transfer of Medical Records at the patient's request (each additional page)	\$0.75

* Referral notes are considered an uninsured service when they are requested by the patient for a service that is not medically necessary.

UNINSURED SERVICES PLAN REGISTRATION FORM

Please complete and return to the Woodbridge Medical Centre

1. My Uninsured Services Plan

- Yes I will subscribe to the Uninsured Services Plan (select one plan)
- Individual \$ 120.00 per person
 - Family \$ 190.00 (includes children to age 18 & full time students)

2. My Information (and family members who are current patients of Woodbridge Medical Centre)

Last Name	First Name	Date of Birth (dd/mm/yy)	Doctor

Address: _____

City: _____ Prov.: _____ Postal Code: _____

Phone: _____

3. My Payment

- Cheque made payable to Woodbridge Medical Centre is enclosed
- Credit Card
- Card# _____ Visa Mastercard
- Expiry Date ____ / ____ Name on Card _____
- Cash/Debit (please make all cash/debit payments in person at the office)

4. My Consent

I agree to pay the above fees that cover the specific uninsured services for a period of one year.

Signature: _____ Date: _____

5. Return the registration form to the Woodbridge Medical Centre by mail or in person

Woodbridge Medical Centre
9600 Islington Ave. Unit A13
Woodbridge, ON L4H 2T1
Tel: (905) 893-8085