

Thank you for seeking Physiotherapy treatment at PHYSIOSOUTH

It is our policy to ensure you are fully informed about the services we provide and the treatment you receive.
It is your right to choose or decline any treatment that is offered.
It is our responsibility to give you the information you require so that you may effectively make that choice.
It is our policy to correspond with your GP. Please let us know if you prefer we did not communicate with your GP.

CLIENT NAME MR/MRS/MS/MISS _____
ADDRESS _____
TELEPHONE HOME _____ **WORK** _____
OCCUPATION _____ **DATE OF BIRTH** ____/____/____
NAME OF NORMAL DOCTOR _____
DRS ADDRESS _____
Would you like to receive information from PHYSIOSOUTH via email Yes No
EMAIL ADDRESS _____

Do you have any specific cultural needs that we need to be aware of? Yes No
Did this accident happen at work? Yes No
Is your employer a part of the accredited workplace scheme? Yes No Unsure
Employers name _____

Have you ever had a treatment for this injury/problem before? Yes No
Who referred you to this clinic? (Please circle)
Doctor Physio Friend/Family Yellow pages Radio Other (specify) _____

For your safety and protection, and for our information, please answer the following questions:

Do you wear a hearing aid or pacemaker? Yes No _____
Do you have any artificial implants?
e.g.. Joint replacements, metal screws Yes No _____
Do you have A.I.D.S. or Hepatitis? Yes No _____
Are you pregnant? Yes No _____
Are you on any long-term medication? Yes No _____
Have you had any recent or major surgery? Yes No _____
Do you have any chronic or serious health problems?
e.g. Epilepsy, diabetes, chronic asthma, heart problem Yes No _____

In accordance with the Privacy Act, all information recorded in your health records will be kept confidential. Your records will only be accessed by the physiotherapist and staff providing your care and service. All personnel in this practice are bound to maintain strict patient confidentiality. Under the privacy act, you have the right to access to and correction of your personal information held by this practice. No information will be given to a third party without your written permission

CONSENT TO TREATMENT AND PAYMENTS:

I hereby give my consent for Physiotherapy treatment bearing in mind that a full verbal explanation will be given at time of treatment and that I can decline treatment at any time. I also give consent for the sharing of information with relevant practitioners involved in my treatment at PHYSIOSOUTH

I undertake to pay for all treatment charges & material costs and pay for any treatment declined by ACC.

I understand that I am liable for any recovery costs required on my account and that after a thirty-day period, there would be a \$15 statement charge for every statement I receive.

I understand that if I fail to attend my appointment without contacting PHYSIOSOUTH I will be liable for a \$20 non attendance fee - we expect a minimum 4 hrs notice.

I understand that if I cancel my appointment without giving 4 hrs notice I may be liable for a \$20 late cancellation fee

Signed _____ Date ____/____/____

Graeme and Marie Nuttridge - Principal Physiotherapists

PUTTING ACTIVITY BACK INTO YOUR LIFE

