Client Consent and Information Form

PERSONAL INFORMATION			
TITLE		PHONE:	
FULL NAME: First and Middle Names		WORK PHONE:	
LAST NAME:		MOBILE:	
PREFERRED NAME: What you like to be known as:		EMAIL:	
GENDER:		HOME ADDRESS:	
DATE OF BIRTH:			
NAME OF GP:		POST CODE:	
MEDICAL PRACTICE:		OCCUPATION:	

HOW DID YOU HEAR ABOUT OUR CLINIC?	☐ Specialist ☐ Physiotherapist ☐ GP	☐ Friend/Family ☐Other ……………………… ☐ Advertising

Are you happy for us to text an appointment reminder to you: ☐ YES ☐ NO

SECTION 2 - GENERAL HEALTH QUESTIONNAIRE:

☐ Pregnant ☐ Physical disability ☐ Diabetes	☐ Heart problems ☐ Skin condition ☐ Cancer ☐ Pacemaker	☐ Hearing/sight impaired ☐ Hep C/HIV ☐ Other (Specify) ………………… ☐ Circulation/Vascular Problem	☐ Asthma/Respiratory/Breathing ☐ Artificial Implants ☐ Allergy (Specify) ………………………………………

HAVE YOU USED OR ARE USING STEROIDS ☐ ANTICOAGULANTS ☐ OTHER MEDICATIONS?

SECTION 3 – CONSENTS

I hereby agree to consent to treatment by an appropriately qualified Physiotherapist for the purpose for providing comprehensive physiotherapy services as may be necessary in support of my illness, injury or condition. I have been given the opportunity to read clinic information prior to treatment. I understand I have the right to decline part or all of the treatment being offered. I understand my right to a second opinion. I agree to consent to a Telehealth Consultation over phone or video communication.

AGREEMENT TO PAY:

I understand that I am liable to pay for:

- Any private treatment or copayment charges for ACC treatments
- If I fail to attend my appointment or cancel without reasonable notice, I may be charged a fee
- If I fail to pay for my appointment at the time of treatment I may be charged an account administration fee
- Any treatment that is declined by ACC or another funder
- The costs of materials such as orthotics, materials, products etc

I understand that if this service requires to engage a Debt Recovery Service to recover my debt, I will be liable for any recovery fees

CONSENT TO RELEASE INFORMATION TO A 3rd PARTY

I consent to the disclosure of my records to any person/organisation necessary for the effective management of my condition.
I consent to a discharge/update report being sent to my doctor or medical centre.

I have read and understand the information above.

SIGNED: **DATED:**
(If under 16 must be signed by parent/guardian

Therapist Initials