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*

Office Use Only:

ENTERED: ☐

SCANNED: ☐

ACC 45 FORM

SECTION 4 - ACC45 -		**PHYSIO TO COMPLETE**	
CLIENT NAME:		**ACC45 No:** (For office use)	
Is this an ACC Injury ☐ YES ☐ No			
Date of Injury:	**Time of Injury:** ☐ **am** ☐ **pm**	**READ CODE/S:** 1 2 3	**SIDE:** ☐ LEFT ☐ RIGHT ☐ LEFT ☐ RIGHT ☐ LEFT ☐ RIGHT
Location: (e.g Christchurch, Auckland)	**Place of Injury:** (e.g. Home, School, Road)	**Additional Injury Comments to injury code**	

How did the injury happen? (Describe)

Ethnicity:	☐ NZ European/Pakeha ☐ Cook Island Maori ☐ Fijian ☐ Indian ☐ Samoan ☐ Other European ☐ Tongan ☐ Other Pacific ☐ Other Asian ☐ Tokelauan ☐ NZ Maori ☐ Niuean ☐ South East Asian ☐ Chinese ☐ Other ☐ I'd prefer not to say
Occupation:	

Please tick those that apply: ☐ I am in paid employment ☐ I own/part-own the company in which I work ☐ I am self-employed ☐ I am not in paid employment

Work Intensity: ☐ Sedentary ☐ Light ☐ Medium ☐ Heavy ☐ Very Heavy

Did the accident occur at work? ☐ YES ☐ NO

What is the name of the business you are employed by/own?	
What is the address of the business you are employed by/ own?	

Is this injury as a result of a motor vehicle accident? ☐ YES ☐ No

Is this injury a result of a sport accident? ☐ YES ☐ No	**Type of sport:**

ACC DECLARATION:

I DECLARE – The information I have given about this claim is true and correct and that I have not withheld any information.
I AUTHORISE – The treatment provider to lodge the claim for me. The collection and release of any information about me to the extent that this is needed to prevent future injuries, determine cover and/or assess my entitlement to compensation, rehabilitation assistance, medical treatment and/or the appropriate level of care and personal attention I should receive. ACC to contact anyone who holds relevant information, including any external agencies or service providers (such as medical practitioners, specialists, New Zealand Police and Treatment Providers, IRD, WINZ, Assessment Agencies, employers and witnesses to the accident.

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

PHYSIOTHERAPIST SIGNED: **DATED:**