Patient Registration Form

sandralangton PHYSIOTHERAPY

Personal Details: Title: Mr / Mrs / Miss / Ms / Dr / Other

Surname:	**First Names:**	**Preferred Name (if any):**	**Date of Birth:**
Address:			
Contact Phone Numbers: Mobile: Home: Work:	**Emergency Contact:** Name: Relationship to yourself: Phone Number:		**GP:** Phone:

Payment Method □ **No Cover** □ **Rural Primary Health Scheme**

□ **Private Health Fund**
Fund name:
Membership number:
Number on card:

□ **Department of Veteran's Affairs (DVA)**
□ Gold Card □ White Card
Card number:
White Card Eligible Condition:

□ **Medicare Details (for CDM Plan holders)**
Medicare Number:
Number on Card:

□ **Worker's Compensation and Insurance claims:**

Insurer:_____ Claim Number:_____ Case Manager:_____

Insurer Phone Number:_____ Date of Injury:___/_____/_____ Referring Doctor:_____

For Workcover: Employer's Name:_____ Contact Phone Number:_____

Medical History (Please tick)

- □ Diabetes
- □ Heart Disease / Pace maker
- □ Blood Pressure
- □ Epilepsy
- □ Cancer
- □ Rheumatoid Arthritis
- □ Osteoarthritis
- □ Osteoporosis
- □ HIV / Hepatitis
- □ Joint Replacement
- □ Blood clots / DVT
- □ Pregnancy (weeks)
- □ Surgery
- □ Stroke
- □ Anxiety
- □ Allergies: (to tape or ointment)
- □ Other:

Office Policies:

Fees and Your Account: Fees for private patients are due at the time of consultation. HICAPS and EFTPOS are available for your convenience.

Workcover and insurance patient accounts will be sent directly to the appropriate body only once the claim has been approved. Please note, it is your responsibility to ensure your claim is approved by Workcover or your insurer. If claiming Workcover please supply a current Workcover Medical certificate.

CDM Plan holders (Medicare funded) need to ensure that they have not received more than their allocated treatment sessions, or Medicare will not issue a rebate.

Privacy Policy: The Privacy Policy for Sandra Langton Physiotherapy can be found on our web page at www.kingaroyalliedhealth.com.au or a hard copy is available for you to read at your request.

Mobile Phones: Out of respect for others, please turn off your mobile phones.

Missed Appointments: Missed appointments will set you back in your recovery, so we ask that wherever possible you keep all appointments. If an appointment must be changed, 24 hours notice is appreciated. If less than 24 hours notice is given, a cancellation fee may be charged. This fee is not covered by compensable bodies. People who repeatedly miss or reschedule appointments will regretfully be discharged from care as we realise you will not reach your health goals. Please inform our reception staff if you wish to have a reminder call given for your appointment.

□ **Reminder call please**

I have read and fully understood the above:

Signed:_____

Informed Consent

Please read the following and sign below:
Physiotherapy treatment is generally an effective and safe form of treatment however like any treatment there are benefits and risks. The purpose of this form is to let you know what your rights are and how we address the issue of a collaborative decision making and informed consent between physiotherapist and patient.

Physiotherapists in this practice will discuss your condition and options for treatment with you so that you are appropriately informed and can make decisions relating to treatment. You may choose to consent or refuse any form of treatment for any reason. You have the right to a second opinion at any time. Once you have given consent, you may withdraw that consent at any time.

The Physiotherapist may exchange information with your Doctor and Medical Specialists when necessary, understanding that this information will be confidential.

Questions of a personal nature: Your physiotherapist may ask personal questions relating to your injury and how your injury impacts on your 'activities of daily living'. The more information you provide, the more likely it is that the physiotherapist can provide effective treatment. It is your choice as to what information you choose to provide. If you feel uncomfortable with a particular question or group of questions, please let the physiotherapist know and they will cease.

Physical contact: During the examination, assessment and treatment it may be necessary for your physiotherapist to make physical contact. Your physiotherapist will ask your permission before making physical contact with you in any way. Wherever possible, contact will be made using a towel or other forms of screening. Physical contact requires your express consent. You may withdraw consent at any time at which point, all physical contact will cease immediately. Please inform your physiotherapist if you feel uncomfortable at any time.

Risk related to treatment: As with all forms of treatment, there are risks and benefits. The physiotherapist will discuss any foreseeable risks with you prior to administering treatment. In some cases, the physiotherapist may ask you to read information related to a particular treatment and they may request that you sign a further consent form. This is to ensure that you fully understand any risks involved. You may withdraw your consent at any time even if you have previously signed a consent form.

Consent to treatment.

Please tick **one** box and complete details before treatment can occur

□ **Personal Consent:** I, _____ (full name) have read and understood the above statements relating to consent for treatment. I offer my consent to receive treatment within the practice. I agree to this consent remaining valid until such time as I withdraw my consent.

Signed: _____ Date: ____/____/_____

□ **Children and Minors:** Consent from a custodial parent or guardian is required to treat a minor.
I, _____(full name of parent/guardian) have read and understood the above statements relating to consent for treatment of _____(full name of minor). I offer my consent for treatment within the practice. I agree to this consent remaining valid until such time as I withdraw my consent.

Signed: _____ Date: ____/____/_____

□ **Substituted Consent:** Where a person is incapable of understanding the risks and benefits of treatment, consent may be provided by another person legally authorized to provide such consent. Evidence of legal authorization is required in such circumstances.
Legal authorization sighted - Signed _____ (staff)

I, _____ (full name) have read and understood the above statements relating to consent for treatment of _____(Clients full name). I offer my consent for treatment within the practice. I agree to this consent remaining valid until such time as I withdraw my consent.

Signed: _____ Date: ____/____/____