CONSENT FORM

Name: Mr/ Mrs/ Miss/ Ms/ Master:……

Address: ……Postcode:…………………..

Phone: (Home):………………………………………… (Work):……………………………………………(Mobile):…………………………………………..

Email Address: ……….

Date of Birth: ………………………………………………………………. Occupation: ………………………………………………………………..

Next of Kin:…………………………………………………………………… Phone: ……………………………………………………………………..

How did you find out about this clinic? ……………………………………………………………………………………………………….

MEDICARE NUMBER: ……………………………….……………………… REF NO: …………………… EXPIRY DATE: ………………………..……

Private Health Insurance Fund Name: □ BUPA □ Medibank □ Other ……………………….

Are you covered by: □ Veterans Affairs □ WorkCover □ Third Party Insurance □ Other

Card Number / Claim Number (if applicable): ……………………………………………………………………………………………

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

- Do you wear a hearing aid? …………………………………………………………………………………………… YES/NO
- Do you wear a pace maker? …………………………………………………………………………………………… YES/NO
- Do you have any artificial implants? Eg. Joint replacement, metal screws, etc ……………………………………… YES/NO

  Please specify ……
- Do you have AIDS, HIV or Hepatitis? ………………………………………………………………………………… YES/NO
- Are you pregnant? (How many weeks?) ……………………………………………………………………………… YES/NO
- Are you on any long term medication? ……………………………………………………………………………… YES/NO
- Have you had any surgery? Eg: Cancer / Heart problems …………………………………………………………… YES/NO
- Do you have Osteoporosis? …………………………………………………………………………………………… YES/NO
- Do you have any chronic or serious health problems? ……………………………………………………………… YES/NO

  Please Specify (Eg. Epilepsy, diabetes, asthma etc ……………………………………………………………………

Injury / Condition: ……

How did you do it? …………………………………………………………Date of Onset: ……………………………………………

Type of Pain: □ Constant □ Intermittent □ New Use □ Overuse

What aggravates the pain? ……………………………………………..What eases the pain? …………………………………………

Is it worse in: □ Morning □ Midday □ Afternoon □ Evening □ Activity Dependent

Have you had any? □ Blood Tests □ X-ray □ Ultrasound □ CT □ MRI □ Operations

Where?

What Exercise / Activities do you do? …………………………………………………………………………………………………

Self-Rating of Fitness: □ Poor □ Average □ Good □ Excellent

Water Intake (daily): ……

CONSENT FORM

CONSENT TO TREATMENT

I hereby give my consent for physiotherapy/massage/exercise physiology treatment bearing in mind that a full verbal explanation will be given at the time of treatment. I have the right to decline part or all of the treatment offered to me at any time, and the right to ask any questions I may have.
PLEASE NOTIFY YOUR TREATING THERAPIST IF YOU WOULD PREFER NOT TO DISROBE

Signed: ………………………………………………………………………………………… Date: ……………………………………………………………..
(If under 16 years of age, please have your guardian sign for you)

PRIVACY CONSENT FORM
This practice has always valued and protected our client's privacy and confidentiality.
Because of an amendment to the privacy act, effective December 2001, we now require your consent to collect personal information about you.
Please read this form carefully and sign where indicated below, so that we may continue to provide you care.
This practice collects information from you for the primary purpose of providing quality health care. We assess, diagnose, treat and are proactive in your health care needs.
This means we will use the information you provide in the following ways:

- Administration purposes in running our practice
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements
- Disclosure to others involved in your health care, including treating doctors and specialist outside this practice. This may occur through referral to other health providers, or in medical tests and in their reports or results to us following the referrals
- Disclosure to other health care professionals in the practice, locums and students attached to the practice for the purpose of patient care and teaching
- Disclosure for research and quality assurance activities to improve individual and community healthcare and practice management
- Emergency situations when medical officers / hospitals require access to patient information for treatment purposes

I have read the information above and understand the reasons why my information must be collected.
I am also aware that this practice has a privacy policy on handling patients' information.
I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the health care and treatment given to me.
I am aware of my rights to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand that I will be given explanation in these circumstances.
I understand that if my information is to be used for any other purpose than set out above; my further consent will be obtained.
I consent to the handling of my information by this practice for the purposes set out above, subject to any limitations on access or disclosure that I notify this practice of.

CANCELLATION POLICY
OUR CLINIC REQUIRES A MINIMUM OF 12 HOURS NOTICE IF YOU DO NOT REQUIRE YOUR APPOINTMENT.
FAILURE TO GIVE ADEQUATE NOTIFICATION WILL RESULT IN A 50% CANCELLATION FEE.

I AGREE TO AMANDA GALE PHYSIOTHERAPY AND WELLBEING CLINICS CANCELLATION POLICY.

……………………………………………………………………………………… ……………………………………………………………………………………….
Signature Print Name

Patient satisfaction is essential to Amanda Gale Physiotherapy & Wellbeing Clinic,
if you are not satisfied with the treating therapist please feel free to change therapist

17 Anderson St, Manunda

4041 7717 | @ info@agphysio.com.au | agphysio.com.au