Patient Information Form

Physio Gym® physiotherapy

We are committed to providing our patients with the best care. To do this it is essential that your record is kept up to date and accurate.

Title ☐ **Dr** ☐ **Mr** ☐ **Mrs** ☐ **Ms** ☐ **Miss**	
Surname	**First Name**
Date of Birth	**Occupation**
Street Address	**Suburb and Post Code**
Home Phone	**Work Phone**
Mobile Phone	Do you wish to receive relevant reminders by SMS? ☐ Yes ☐ No
Email	Do you wish to be emailed relevant information? ☐ Yes ☐ No
Emergency Contact Name	**Emergency Contact Phone**
Referral Details	☐ **GP** ☐ **Specialist** ☐ **Sports club** ☐ **Other** ________________
Name	**Practice/Club**
Address	**Suburb and Post Code**
Phone	**Fax**
Medicare Number ___ ___ ___ ___ – ___ ___ ___ ___ ___ – ___	**Patient Reference Number** **Expiry**
Document checklist ☐ GP referral letter	☐ Referral Form for Individual Allied Health Services under Medicare (formerly EPC)
Private Health Insurance	**Member Number** **Patient Reference**
Workers Compensation/Compulsory Third Party Insurance (CTP)	**Claim Number**
Employer	**Insurance Company**
☐ Referral letter from nominated treating doctor (NTD)	**Case Manager**
☐ Letter from insurance company "accepting liability"	**Phone**
☐ WC Medical Certificate of Capacity	**Fax**

Patient Background Australia is a genuinely multicultural society. To tailor appropriate care, encourage understanding and appreciation between people from different nationalities and backgrounds.

Do you identify as someone from a culturally and/or linguistic diverse background?

☐ No ☐ Yes. Please elaborate:

To assist with health initiatives – are you an Aboriginal or Torres Strait Islander?

☐ No ☐ Yes – Torres Strait Islander ☐ Yes – Aboriginal ☐ Yes – Aboriginal & Torres Strait Islander

Patient Consent

☐ **24-Hour Cancellation Policy:** I,_________________________, understand cancelling a physiotherapy treatment session within 24 hours of the appointment will incur the total cost of that session.

☐ **Use of personal health information within the Practice:** I give permission for my physiotherapy records and personal information to be shared between physiotherapists of this practice. I understand that all physiotherapists and staff of this practice are covered by confidentiality agreements. I also understand that should I not want my physiotherapy or personal information disclosed to other physiotherapists or staff of this practice I need to inform my usual physiotherapist of this issue.

☐ **Use of personal health information outside the Practice:** I agree to allow my physiotherapist to communicate relevant physiotherapy details to GPs, Specialist Doctors, Hospital Medical Staff, Medical Imaging centres (e.g. X-ray, MRI scan, CT scan) and other Health Care Providers (e.g. Podiatrists) involved in my physiotherapy care.

This practice from time to time participates in physiotherapy research projects with outside organisations. We stress that all information shared is ***depersonalised*** (i.e. names of patients are not given). If you DO NOT want any of your clinical information used in this manner, please indicate with a cross in the following box. ☐

☐ **Workers Compensation/CTP:** I understand that my account can be held up to 14 days until I have given all the claim details above. If my claim has been denied or the above claim details have not been given within 14 days, I am responsible for the payment of my account.

I understand cancelling a physiotherapy treatment session within 24 hours of the appointment will incur the total cost of that session. This will be billed to me personally, not to the insurance company.

☐ **For Dependant:** As Parent/Guardian of____________________________________ I authorise that their health information be also used in the above mentioned manner.

Your signature
Patient/Parent/Guardian ____ **Date** ____________________________________

Witness signature ___________________________________ **Witness name** ____________________________________