Therapy for Life

PHYSIOTHERAPY

Client Detail Form

PLEASE FILL IN BOTH SIDES WHERE APPLICABLE USING BLOCK LETTERS

Your appointment is:

Private☒ Workcover☐ MVA☐ Vet Affairs☐ CDM☐ Other Compensable☐

Surname: _____ Home Phone: (____) _____

Given Names: _____ Work Phone: (____) _____

Preferred Name: _____ Mobile Phone: _____

Date of birth: ____/____/_____ Male ☐ Female ☐

Country of Birth: _____

Are you of Aboriginal or TSI origin? Yes, Aboriginal ☐ Yes, TSI ☐ Yes, Both ☐ No☒

Next of Kin: _____ Contact Number: _____

Relationship: _____

Name of Health Insurance Fund (if applicable): _____

Email (optional): _____

Please present your Medicare card when you return this form.

Residential Address: _____

Town/City: _____ Post Code: _____

Postal Address (if different): _____

Town/City:_____ Post Code: _____

Please note, any person under the age of 18 years of age **MUST** have consent of a parent or legal guardian. If under 16 years of age, the patient **MUST** be accompanied by an adult.

Name of Parent/Guardian: _____

Relationship to patient: _____

Is the patient under the guardianship of the minister? ☐Yes ☒ No

How did you hear about us?

☐ Doctor / Specialist ☐ Rehab Consultant

☐ Internet ☐ Find a Physio website

☐ Yellow pages ☐ Referral from friend or family

☐ Other, Please Specify: _____

Administrative use only: MCN: __ __ __ __ __ __ __ __ __ __ __ PN: __ ED: ____ / ____

Referring Doctor/Specialist: _____

(Please note referral is not required for private clients)

Doctors Clinic Attended: _____

Please answer the following questions, if you have any difficulties, please ask for assistance:

Pension or Centrelink Health Care Card? _____ Yes☐ No☐

A pace maker or electronic implant? _____ Yes☐ No☐

Sensitivity to tapes? _____ Yes☐ No☐

Sensitivity to creams? _____ Yes☐ No☐

Sensitivity to latex or rubber? _____ Yes☐ No☐

Any other allergies? _____

Any difficulty feeling heat or cold? (Cannot tell if you're too hot or too cold) _____ Yes☐ No☐

Any other loss of sensation that may affect treatment? _____ Yes☐ No☐

If so, where: _____

Transmittable infection/disease? _____ Yes☐ No☐

Any other condition that may affect treatment? _____ Yes☐ No☐

If so, what condition: _____

Have you had a previous bad experience with any physiotherapy treatment? _____ Yes☐ No☐

PLEASE READ CAREFULY

IMPORTANT: Cancellations must be made with at least 24 hours notice prior to your appointment otherwise a non-attendance fee may apply. Compensable clients will be billed for this fee **personally** and it becomes your responsibility to pay it. Reminder sms texts are a courtesy; they should not be used in lieu of your own responsibility in remembering your appointments. If any equipment on loan is not returned, or returned in an unsatisfactory condition, a replacement fee may apply. Any compensable claims, in part or full, that are not paid by the covering insurance agency **will become the responsibility of the client. The client must then settle outstanding amounts in full within 30 days.** If there is any failure to attempt to settle accounts in this time, a third party recovery service may become involved to recoup outstanding amounts, incurring additional recovery fees to the client.

In accordance with the current Privacy Act we reserve the right to destroy any patient records exceeding 7 years. All information provided will be treated with the utmost respect and confidentiality, in accordance to part 5, sections 64 to 64D of the South Australian Health Commission Act 1976. If you require an extract of this Act, please ask the reception staff.

It is sometimes necessary to communicate with your Doctor or specialist, therefore we will be required to pass on information about you and your condition to them. If you are seen in our Millicent clinic, please be aware that a hospital file will be created, but will contain minimal information.

We ask for all non compensable accounts to be settled on the day of treatment and we have provided HICAPS and EFTPOS for your convenience.

If you have had any transmittable illnesses (e.g. flu, gastro) 48hrs prior to your appointment, please notify this office so your appointment can be changed.

☐ I agree and have understood the above policy.

☐ I disagree with the above policy
(we reserve the right to refuse service)

I state the personal information I have provided is true and correct by the application of my signature below.

Signed: _____ Date: ____/____/____

(to be signed by Parent/Guardian if under 18yrs)