Performance Rehab Physiotherapy Patient Consent Form

Personal Information	
Title: Dr Mr Master Mrs Ms Miss	
First Name:	**Mobile Number:**
Last Name:	Work Number:
Known as:	Home Number:
Gender:	Email:
Date of Birth:	Occupation:
Ethnicity:	**Home Address:**
Name of GP: Name of Medical Centre:	

Emergency Contact Details	
Name: Relationship to patient:	Phone Number:

General Health Questions (please circle if applicable)			
Pregnant HIV/Hep C Cancer On anticoagulants	Osteoporosis Hearing Impaired Sight Impaired Use steroids	Skin conditions Pacemaker Diabetes Allergies (specify)	Artificial implants Asthma Heart Conditions
Medications:			

Consent to Treat

1) I hereby give consent for an initial physiotherapy assessment followed by information on a treatment plan as seen a necessary in support of my illness, injury or condition.
2) I have the right to decline treatment at any stage
3) I have the right to a second opinion
4) I have the right to have a support person present if I so choose.

Disclosure of Information

1) I consent to updates, reports and letters being sent to my healthcare provider.
2) I consent to disclosure of medical records for effective management of my condition.

Agreement to Pay

1) I understand I am liable for the private or ACC co-payment fees per treatment.
2) I understand if ACC declines my claim all fees will turn to private charges.
3) I understand if I miss an appointment or cancel within six hours of my appointment, I will incur a ***$30 late cancellation or no show fee***.
4) I understand any unpaid debt (no credit policy) will be recovered by the Debt Recovery Service and any additional recovery fees incurred will be passed on.

Referral Source – How did you find us

Doctor Referral __   Signage __   Family/Friend__
Previous Patient__   Editorials/Articles (which one)_____
Google Search __   Advertising (where)_____
Other (please specify)

Signed (if under 16 guardian name and signature required)	Date: