

GENERAL PATIENT INFORMATION FORM - NORTH CITY PHYSIOTHERAPY

The following information is required so we can uniquely identify you, supply accurate information to ACC about your injury (where required) and provide statistical data in the use of national health planning and policy.

PLEASE COMPLETE BOTH SIDES OF THIS FORM

Full Name:			
Postal Address:			
Home Phone:		Work Phone:	
Mobile:		Date of Birth:	
Email address:			
Ethnicity:		Usual GP:	
Occupation:		Employer:	
Employers Address:			
Please tell us who you would like us to contact, in the event of an emergency			
Name:		Relationship to you	
Contact details:			
Your information is helpful, however the following 2 questions are for statistics only and not compulsory			
How did you hear about us?	<input type="checkbox"/> Doctor <input type="checkbox"/> Previous Patient <input type="checkbox"/> Word of mouth <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Local directory <input type="checkbox"/> KCP Physio clinic <input type="checkbox"/> Newspaper <input type="checkbox"/> Signage <input type="checkbox"/> Flier <input type="checkbox"/> Specialist <input type="checkbox"/> Other (please specify):		
Why did you choose us?	<input type="checkbox"/> GP referred me <input type="checkbox"/> Reputation <input type="checkbox"/> No cost <input type="checkbox"/> Location <input type="checkbox"/> Hours <input type="checkbox"/> Able to get appointment <input type="checkbox"/> ACC Accredited <input type="checkbox"/> Advertising <input type="checkbox"/> First one I called <input type="checkbox"/> No particular reason <input type="checkbox"/> Other (please specify):		

Information referral to a 3rd party other than my GP:

- I consent to the disclosure of my records, to any person / organisation necessary for the effective management of my condition. (E.g. Specialist if referred, Case manager (with ACC, Private Insurer) Employer, Sports team coach)
- I consent to a discharge/update report being sent to my doctor/medical clinic

TERMS OF ENGAGEMENT – YOUR AGREEMENT IS NECESSARY BEFORE TREATMENT PROCEEDS

Clinic Brochure:

- I have read and understood the North City Physiotherapy clinic brochure.

Agreement to Pay:

- I understand that I am liable to pay
- For treatment charges and the **costs of materials** (splints, collars etc.)
 - Any treatments **declined** by ACC or any other funder.
 - A **non-attendance fee of \$40.00**, if I fail to notify the North City Physiotherapy clinic I am attending **at least 2 hours** in advance to cancel a scheduled appointment, or if I **do not attend** a scheduled appointment.

Complete the following section AFTER Consultation with your Physiotherapist

INFORMED CONSENT TO TREATMENT

Where relevant to my treatment plan, the following have been explained to me and I have had an opportunity to ask questions. I understand that I have the right to decline part or all of the treatment offered to me at any time. I understand my treatment plan and consent to being treated by a North City Physiotherapist.

<input type="checkbox"/>	Electrotherapy	<input type="checkbox"/>	Manipulation	<input type="checkbox"/>	Mobilisation	<input type="checkbox"/>	Acupuncture (further consent req.)
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Signature: _____

Date: _____

(If under 16, must be signed by parent/guardian)

(PLEASE COMPLETE OTHER SIDE)

