BodyCare
Physiotherapy

Mr / Mrs / Ms / Miss / Mast / Dr

Surname: ______________________________ Given Names: ______________________________

Address: _______________________________ Suburb: __________________ Post Code: _____

Date of Birth: ___________________________ Occupation: _______________________________

Home Phone: __________________________ Work Phone: _______________________________

Mobile: ________________________________ Fax No: ___________________________________

Email Address: _____________________________________________________________________
□ Please Tick if you DO NOT wish to receive information about services offered from Body-Care Physiotherapy.

Emergency Contact: _________________________________________________________________

If patient is under 18 years of age, account to be Charged: _______________________________

Private Health Insurance: _____________________________________________________________

DVA / Pensioner No (if applicable): ___________________________________________________

GP Name / Address: _________________________________________________________________

Do you have a pacemaker / metal implant or major Health Problem?
YES / NO If yes, details: ______________________________________________________

** I understand that should this be an insurance claim, I accept that I am irrevocable responsible for payment of my account.*
*** I certify that all information given to be true and correct*

**PATIENT TO PLEASE READ THE FOLLOWING:**
**Heat Treatment:** When receiving heat treatment, all you should feel is a mild comfortable warmth. If you feel any more than this you must notify the physiotherapist immediately as there is a possibility you may be burnt.
**Electrical Stimulation:** When receiving electrical stimulation, any concentration of the current, discomfort or pain must be reported immediately to the physiotherapist. Otherwise there is a possibility of sustaining an abnormal skin reaction or tissue damage.

Signature: ___________________________________ Date: ____________________________

# CONSENT FORM

*We require your consent to collect personal information about you. Please read the information and sign where indicated below.*

I understand that the purpose for collecting my personal information is to provide me with quality medical, physiotherapy, podiatry, and health related services and associated account keeping. This includes the release of relevant information to other health professionals involved in my medical care such as specialists, pathology services, radiology, general practitioner, physiotherapist and other allied health service providers.

I understand I have the right to request access to my information. I understand that I may withdraw my consent for this practice to use and disclose my personal information, except where legal obligation must be met. I understand that I am not obliged to provide any information requested of me, but my failure to do so will compromise the quality of health care treatment given to me.

Name: ____________________________________________

Signature / Guardian: ___________________________ Witness: ________________

## WORKERS COMPENSATIONS CLAIMS ONLY

Employer:_________________________________ Claim No: _________________________

Date of Injury: _____________________________

Insurance Company: _______________________ Contact Name: _____________________

I _____________________ hereby authorise Bodycare Physiotherapy to divulge to my employer / insurer / solicitor, any information relevant to my workers compensation claim and I confirm that I am aware that should the employer / insurer decline payment that I will be irrevocable responsible for payment of the accounts.

Signed: ___________________________ Date: ________________ Witness:___________

## MOTOR VEHICLE CLAIMS ONLY

Insurer:____________________________ Solicitor: _________________________________

Claim No: ___________________________ Date of Accident: _________________________

I ______________________ hereby authorise Bodycare Physiotherapy to divulge to my solicitor / insurer any information relevant to my Motor Vehicle Claim and I confirm that if for any reason the insurer declines payment that I am irrevocable responsible for payment of these accounts.

Signed: ___________________________ Date: ________________ Witness:___________