beechboro physiotherapy

## How did you hear about us?

☐ Referral (can be from friend, family or Doctor)

Referrer Name: _____

☐ Website: _____

☐ Yellow Pages: online ☐ phone book ☐

## Contact Details

Dr ☐ Mr ☐ Mrs ☐ Ms ☐ Mstr ☐ Miss ☐

Surname: _____

Given Name: _____

DOB: __ __ / __ __ / __ __ __ __

Address: _____

_____

_____ __ __ __ __

Phone H: _____

M: _____

Email: _____

Occupation: _____

Sport/Hobby: _____

## In case of Emergency

Contact: _____

Relation: _____

Phone: _____

## Other Details

Do you have Private Health Cover? Yes / No

Fund Name: _____

GP Name: _____

GP Address: _____

### Claims

Private ☐

Pensioner (Aged & Disability Pensioner) ☐

Veterans Affairs ☐

DVA Number: _____

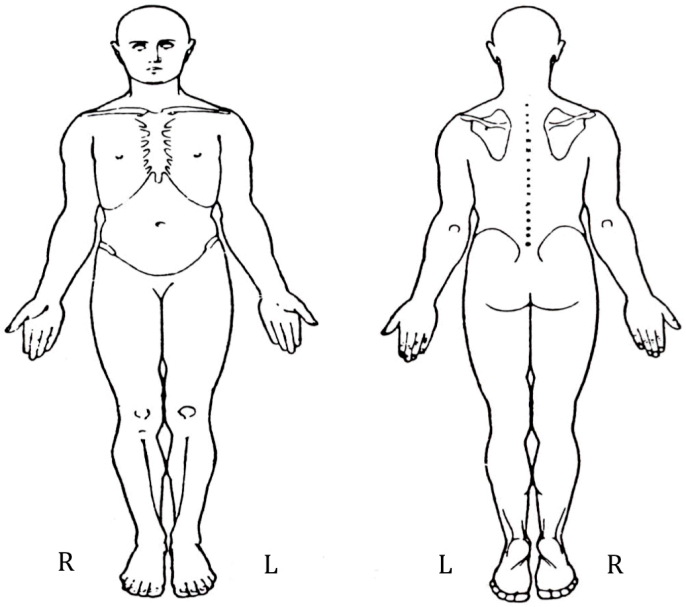
Card Type: _____

Workers Compensation ☐

Motor Vehicle Accident ☐

Enhanced Primary Care Plan ☐

Please circle area of pain:




Brief Description of Problem:

_____

_____

Write down two goals you hope to achieve from physiotherapy treatment:

1. _____
2. _____

Check if you have any of the following health problems:

| ✔ | | ✔ | |
|---|---|---|---|
| | Asthma | | Cancer / Tumor |
| | Diabetes I / II | | Heart Disease |
| | HIV/AIDS | | Lung Disease |
| | Osteoporosis | | Spinal Fractures |
| | Stroke | | Psoriasis |
| | Hepatitis | | Epilepsy |
| | Rheumatoid Arthritis | | |
| | Other: | | |

Do you have an Implanted Cardiac Pacemaker or other device? Yes ☐ No ☐

Do you have any metal implants? Yes ☐ No ☐

Have you, or are you receiving physiotherapy elsewhere? Yes ☐ No ☐

## Workers Compensation / Motor Vehicle Accident

Date of Accident: __ __ / __ __ / __ __ Claim Number: _____

**Employer:** _____ **Insurer:** _____

Address: _____ Address: _____

_____ _____

Contact: _____ Contact: _____

Phone No. _____ Phone No. _____

I _____ hereby authorize any professional staff member of Beechboro Physiotherapy, to divulge to my employer and/or my employer's insurer, or the motor vehicle third party injury insurer with information in relation to my workers compensation or motor vehicle personal injury claim (whichever is applicable to me), which he/she had acquired in regards to myself. I am also aware that if liability for my claim is declined that I am ultimately responsible for payment of any costs I have incurred in relation to my treatment. As well as any costs involved in the recovery of this amount.

**Signature _____ Date ____/____/____ Witness _____**

---

## Declaration/Consent

**Cancellation Policy:**

At Beechboro Physiotherapy, we strive to ensure that our client's physiotherapy needs are met in a timely and convenient way. This can result in high demand for appointment times. Consequently, we ask that if your appointment needs to be rescheduled or cancelled, please note the following policy:

Late Cancellation Policy

We require 8 hours notice to cancel or rearrange your appointments.
If insufficient notice is given you will be invoiced a cancellation fee of $30.

Non-Attendance/Missed Appointment Policy

If you fail to attend your appointment without providing sufficient notice you will be invoiced a missed appointment fee $60.
**Note: These fees cannot be passed on to Workers Compensation, Motor Vehicle Insurance or your Private Health Insurance Company.*

**Treatment Warnings:**

Heat Treatment:

When receiving a heat treatment all you should feel is mild, comfortable warmth. If you feel any more than this, or if the pain is concentrated in any particular spot, you must call your physiotherapist immediately, otherwise you may be at risk of being burned.

Electrical Stimulation:
When receiving an electrical stimulation, any concentration of the current, or discomfort or pain must be reported immediately to your physiotherapist, Otherwise you may be in danger of sustaining an abnormal skin reaction. This may result in skin and tissue damage.

By providing your email, address and contact numbers you are consenting the use of them by the practice. Your details are confidential and will only be used by Beechboro Physiotherapy Centre. We thank you for your understanding and compliance, please talk to your therapist if you have any queries. Further details on this policy may be obtained from reception.

**Declaration:**

**I _____ (full name) have read and fully understand the above statements. I understand that I am ultimately responsible for the payment of my account.**

**If under 18 account to be charged to: _____**

**Signature _____ Date ____/____/____**