SOUTHERN PHYSIO

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CONSENT TO TREATMENT

Section 1: PERSONAL INFORMATION

Full Name:	Mr / Mrs / Ms / Miss			
Known as:		**DOB:**		
Address:		**Mobile:**		**Home:**
		◯ Yes ◯ No	**Are you happy for us to text an appointment reminder to you?**	
Medical Practice:		**Email:**		
GP:		**Ethnicity:**		
Occupation:		**Do you have any special cultural requirements we need to be aware of? ❑ YES ❑ NO If yes,**		
Work Intensity:	❑Sedentary ❑Light ❑Medium ❑Heavy			
Employer Name: (if work related injury)		**Employer Address:** (if work related injury)		

How did you hear about our clinic : ◯ Web Search ◯Been Before ◯ Suggested family/friend◯ GP ◯Physio ◯Specialist ◯Local Signage ◯ Facebook ◯ Radio ◯ Sth Cross Easy Claim ◯ Other_____

Section 2 – GENERAL HEALTH QUESTIONNAIRE

◯ Pregnant ◯ Physical Disability ◯ Thyroid Problems ◯ Heart Problems ◯Skin Condition	◯ Diabetes ◯ Cancer ◯ Pacemaker ◯ Hep C/HIV ◯ Circulation/Vascular Problem	◯ Epilepsy ◯ Hearing/Sight Impaired ◯ Asthma/Respiratory ◯Artificial Implants ◯ NO medical/Health Concerns	◯ Other _____ _____ _____ Allergies (Specify) _____

HAVE YOU USED OR ARE USING
◯ **STEROIDS** ◯ **ANTICOAGULANTS**

◯ **LIST CURRENT MEDICATION**
_____

Is this an ACC Injury ◯YES ◯ No
Have you completed a ACC form ◯YES ◯ No **ACC NUMBER** _____ **Date of Injury** _____

Section 3: CONSENTS

In accordance with the Privacy Act, all information recorded in your health records will be kept confidential. Your record will only be assessed by the physiotherapists providing your care & by those office staff responsible for filing. All personnel in this practice are within their employment contract, bound to maintain strict patient confidentiality. No information will be given to third party other than ACC or your Workplace Insurer, without your written permission.

I hereby give my consent to treatment bearing in mind that a full verbal explanation will be given at the time of treatment. I have the right to decline part or all of my treatment given offered to me. I understand the clinician may discuss my treatment with other clinicians at Sportsmed Southland, in line with the clinics' multidisciplinary approach.

AGREEMENT TO PAY: I understand that I am liable to pay for:

- Any private treatment or co-payment charges for ACC treatments as well as any treatment that is declined by ACC or other funder
- If I fail to pay for my appointment at the time of treatment I may be charged an account administration fee.
- The costs of materials such as orthotics, strapping tape, products etc
- I understand that if this service requires engaging a Debt Recovery Service to recover my debt, I will be liable for any recovery fees.

If I fail to attend my appointment or cancel without 3 hours' notice I may be charged a Cancellation or No Show fee of $30

ACC DECLARATION: I declare – the information I have given about this claim is true & correct & I have not withheld any information.
I authorize – the treatment provider to lodge the claim for me. The collection & release of any information about me to the extent that this is needed to prevent future injuries, determine cover &/or assess my entitlement to compensation, rehabilitation assistance, medical treatment, &/or the appropriate level of care & personal attention I should receive. ACC to contact anyone who holds relevant information, including any external agencies or service providers (such as medical practitioners, specialists, NZ Police & treatment providers, IRD, WINZ, Assessment agencies, employers & witnesses to the accident).
CONSENT TO RELEASE INFORMATION TO A 3rd PARTY: I Consent to a discharge/update report being sent to my Doctor.

*****Signed:** **(under 16 must be signed by parent/guardian)** Date:

PHYSIOTHERAPIST SIGNED: Date

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