BODY LOGIC PHYSIOTHERAPY

PATIENT INFORMATION FORM

We are committed to providing our patients with the best care. Please assist us by completing the following information. PLEASE WRITE CLEARLY IN CAPITAL LETTERS.

Title:_____Surname: _____First name: _____

Preferred Name: _____Date of Birth: _____ Male / Female

Address: _____Postcode: _____

Work No: _____Occupation: _____Mobile: _____

Home Phone No: _____Personal Email address: _____

Who referred you to our clinic today? _____

Name & address of Referrer/GP: _____

_____

Next of Kin: _____Relationship_____ Contact No: _____

Communication with our patients is our priority. We send SMS reminders for appointments and to optimise your care we may email you at times. Please discuss with reception if you would like to opt out of either SMS or email.

Name of Person Responsible for Account (If different from above): _____

Address: _____

Dept. Veteran Affairs No (if applicable): _____ DVA Expiry Date: _____ Card Colour:_____

Conditions covered by DVA for non Gold card holders: _____

Complete only if Workers Compensation or Motor Vehicle Accident Claim:

Date of injury or accident: _____Claim number: _____

Insurance Company/ Case Manager/ IMA: (please provide a name and address of person responsible for account):

_____

_____

Is liability for this claim current? YES ☐ NO ☐

ALL PATIENTS PLEASE READ AND SIGN

DECLARATION: I understand and agree that:

1. If I am unable to attend my appointment I will give 24 hours notice of my cancellation. If I do not cancel with notice I will be charged a Non-Attendance Fee for my missed appointment.
2. I am required to pay on the day for all consultations. Body Logic Physiotherapy accepts cash, cheques and has EFTPOS & HiCaps facilities. If my account is not paid at the time of consultation, administration fees may be added.
3. In the event that my accounts are outstanding longer than 45 days, I will be responsible for all collection fees incurred.
4. For insurance claims, I will be personally responsible for payment of all accounts incurred by me in the event that liability is denied, or placed in dispute by the insurance company.
5. I consent to treatment provided by the physiotherapist.

Signature: _____ Date: _____

PRIVACY STATEMENT

Your personal health information and your Records may be collected, used and disclosed, including but not limited to, the following reasons:

- For communicating relevant information with treating doctors, specialists, insurers or other allied health professionals
- For use by all physiotherapists in this group practice, when consulting with you
- For research purposes (de-identified, meaning you are not able to be identified from the information given)

If you have any concerns or wish to restrict access to your personal health information, please discuss these with your treating physiotherapist.