ULTIMATE PHYSIO

Welcome to our Clinic. Please fill out the following details as clearly and fully as possible. If you have any questions regarding this form, please ask at reception for assistance. **Please ask if you need to use a toilet facility**.

FULL NAME: _____ PREFERRED NAME: _____

ADDRESS: _____

DATE OF BIRTH: _____/_____/_____ Age: _____ OCCUPATION: _____

HOME PHONE #: _____ WORK PHONE #: _____ MOBILE #: _____

EMPLOYER: _____ USUAL DOCTOR: _____

EMERGENCY CONTACT: _____ PHONE #: _____

EMAIL:_____ Do you want to receive information via email? Yes/No

Do you wish to receive text reminders for your appointments? Yes/No

How did hear you about us: □ Friend □ Doctor □ Yellow pages Signage Other _____

	YES	NO
Do you have any artificial implants?	□	□
(Joint replacements, metal screws, pacemaker, hearing aid?)		
Do you have Aids, Hepatitis B or C?	□	□
Are you pregnant?	□	□
Are you on any long term medication?	□	□
Which? _____		

WHAT IS YOU ETHNIC BACKGROUND?

□ NZ European
□ NZ Maori
□ Other European _____
□ Pacific Island _____
□ Asian _____
□ Other _____

Do you have any chronic health problems? □ □
(E.g. epilepsy, diabetes, chronic asthma/bronchitis, bleeding disorder: previous history of cancer; high or low blood pressure; fainting, hearing problems, etc) _____

Did this injury happen at work? _____
Are you covered by ACC or another private insurer? _____

In accordance with the Privacy Act, all information recorded in your health records will be kept confidential. No information will be released without your consent. You are entitled to ask to view your records at any time. I authorize the collection & disclosure of any information about me for the purpose of any rehabilitation assistance, or further medical treatment (referral to specialists or other health providers) – I understand that this will be discussed with me before the information will be released

CONSENT TO TREATMENT

I agree to have a physiotherapy assessment for my current condition, bearing in mind that a full verbal explanation will be given at the time of treatment so that I may make an informed choice. I have the right to decline part or all of the treatment offered to me at any time.

AGREEMENT TO PAY

I undertake to pay for treatment charges and costs of materials/supplies (splints, strapping materials, needles, etc) and to pay for any treatments declined by ACC or private Insurer. *Payment for treatment is due on the same day*. I am aware that if I fail to meet the payment requirements I will be liable for all costs of collection and recovery of any outstanding debt.

If I fail to notify Ultimate Physio Services at least 4 hours in advance, to cancel a scheduled appointment, I agree to pay a fee for non-attendance of $49.00

FEES	**Private**	**$72.00 for initial visit**	**$49.00 for follow up visit**
	ACC	**$29.00 for initial visit**	**$18.00 for follow up visit**

SIGNED: _____ **DATE:** _____

Under16 years of age – consent of parent or guardian is required.