SPORTS & SPINAL
PHYSIOTHERAPY

Treatment Fees:

$27.00 ACC Co-Payment per Session
$22.00 ACC Co-Payment per Session (CSC/Students/Gold Card holders)
$62.00 Private Condition Session
Please see Reception for Daniel Harvey`s fees

Mr / Mrs. / Miss / Ms / other (circle one)

Legal First Name **Last Name**

Preferred Name: **Occupation**

Day/Month/Year

DOB : / / **Home Ph** **Mobile:**

Full Address:

Email Address:

Do you have any specific cultural needs, values and beliefs (OPTIONAL) Yes ☐ No ☐

Doctor's Name/Practice

Next of kin contact name **Phone Number:**

Ethnic Background
☐ NZ European / Pakeha ☐ Cook Island Maori ☐ Fijian ☐ Samoan ☐ Tongan
☐ Other Pacific ☐ Other Asian ☐ Tokelauan ☐ European ☐ Indian
☐ NZ Maori ☐ Niuean ☐ South East Asian ☐ Chinese ☐ Fijian/Indian
☐ I'd prefer not to say
☐ Other ethnic group, *please specify*

- ***Are you referred by? (Tick one)***

Self ☐ **Doctor** ☐ **Specialist** ☐ **ACC** ☐ **Employer** ☐

Other – please give details

Is this a work related injury? **Yes/No**

If yes, who is your employer (company name?)

Company Address:

Is your employer an accredited company? Yes ☐ No ☐

(Accredited means they cover their own workplace injuries and not ACC)

Health / Medical Details - For your safety and protection, and for our information.

	Yes	**No**
Have you previously received physiotherapy for **this** condition?	☐	☐
Have you ever had any major surgery? (i.e.: Heart bypass etc.)	☐	☐
Have you had recent surgery of any kind?	☐	☐
Do you wear a hearing aid or pacemaker?	☐	☐
Do you have any artificial implants – e.g., metal screws / joint replacement?	☐	☐
Do you have AIDS / HIV / Hepatitis / MRSA?	☐	☐
Do you have a personal or family history of cancer?	☐	☐
Are you pregnant?	☐	☐
Are you on long term medication?	☐	☐
Do you have any allergies to tape or medications?	☐	☐
Have you ever been diagnosed with high blood pressure?	☐	☐
Do you have any serious health problems? e.g. Epilepsy / diabetes / asthma / bronchitis / heart problems / high cholesterol / blood clotting disorders / osteoporosis / arthritis / rheumatoid arthritis / ankylosing spondylitis / other_____	☐	☐
Are you receiving ACC weekly entitlements?	☐	☐
In the past month, have you had little interest or pleasure in doing things?	☐	☐
In the past month, have you been feeling down, depressed or helpless?	☐	☐
Are you or have you ever been a smoker?	☐	☐

Have you had any recent/new/unusual or atypical: (tick if yes)

☐ Weight loss/gain	☐ Vomiting	☐ Dizziness	☐ Nausea	☐ Weakness
☐ Speaking/Swallowing	☐ Double vision	☐ Fatigue	☐ Fever	☐ Chills
☐ Numbness/tingling	☐ Pins & Needles	☐ Headaches	☐ Fainting	☐ Sweats

<u>Are you happy to receive a text reminder of your appointments</u>? **Yes:** ☐ **No:** ☐

<u>DECLARATION</u>

I hereby give consent for physiotherapy assessment and treatment bearing in mind a full verbal explanation will be given by the physiotherapist.
I have the right to decline part or all of the treatment offered to me at any time. I can ask for a second opinion or change my treatment provider in accordance with Section 7 of the Code of Health & Disability Services Consumer Rights 1996.
I undertake to pay for any goods or materials supplied to me (splints, tape etc.)
I undertake to pay for any treatments that are declined by ACC or my private insurer.
I agree to give at least 3 hours' notice for cancellation. Failure to do so will incur a $27.00 fee which I agree to pay for within 14 days of invoice.
Please note that payment is preferred at time of treatment. All unpaid accounts will be forwarded to our debt recovery company and you will be charged collection fees.
In accordance with the Privacy Act, all information recorded in your health records will be kept confidential. Your record will only be accessed by the Physiotherapist providing your care and by those office staff responsible for filing. All personnel in this practice are bound to maintain strict patient confidentiality within their employment contract. Under the Privacy Act, you have the right of access to, and the correction of, your personal information held by this practice. No information will be released without your consent.

Signature: **Date:**