

Treatment Fees:

\$35.00 ACC Co-Payment per Session

\$30.00 ACC Co-Payment per Session (CSC/Students/Gold Card holders)

\$70.00 Private Condition Session, \$60.00 Private Condition Session (CSC/Students/Gold Card holders)

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: **NHI#:**

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

Ethnic Background

<input type="checkbox"/> NZ European / Pakeha	<input type="checkbox"/> Cook Island Maori	<input type="checkbox"/> Fijian	<input type="checkbox"/> Samoan	<input type="checkbox"/> Tongan
<input type="checkbox"/> Other Pacific	<input type="checkbox"/> Other Asian	<input type="checkbox"/> Tokelauan	<input type="checkbox"/> European	<input type="checkbox"/> Indian
<input type="checkbox"/> NZ Maori	<input type="checkbox"/> Niuean	<input type="checkbox"/> South East Asian	<input type="checkbox"/> Chinese	<input type="checkbox"/> Fijian/Indian
<input type="checkbox"/> I'd prefer not to say				
<input type="checkbox"/> Other ethnic group, please specify <input type="text"/>				

• **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?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had any major surgery? (i.e.: Heart bypass etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Have you had recent surgery of any kind?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear a hearing aid or pacemaker?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any artificial implants – e.g., metal screws / joint replacement?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have AIDS / HIV / Hepatitis / MRSA?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a personal or family history of cancer?	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Are you on long term medication? Please list _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any allergies to tape or medications? Please list _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been diagnosed with high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
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 _____	<input type="checkbox"/>	<input type="checkbox"/>
Are you receiving ACC weekly entitlements?	<input type="checkbox"/>	<input type="checkbox"/>
In the past month, have you had little interest or pleasure in doing things?	<input type="checkbox"/>	<input type="checkbox"/>
In the past month, have you been feeling down, depressed or helpless?	<input type="checkbox"/>	<input type="checkbox"/>
During the past month have you been worrying a lot about everyday problems?	<input type="checkbox"/>	<input type="checkbox"/>
Are you or have you ever been a smoker?	<input type="checkbox"/>	<input type="checkbox"/>

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

<input type="checkbox"/> Weight loss/gain	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Nausea	<input type="checkbox"/> Weakness
<input type="checkbox"/> Speaking/Swallowing	<input type="checkbox"/> Double vision	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Fever	<input type="checkbox"/> Chills
<input type="checkbox"/> Numbness/tingling	<input type="checkbox"/> Pins & Needles	<input type="checkbox"/> Headaches	<input type="checkbox"/> Fainting	<input type="checkbox"/> Sweats

Are you happy to receive a text reminder of your appointments? Yes: No:

DECLARATION

I hereby give consent for physiotherapy assessment and treatment bearing in mind a full verbal explanation will be given by the physiotherapist. I consent to a report on my condition being sent to my GP/referrer.

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 \$35.00 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: