Sports & Spinal Physiotherapy Consent Form

Personal Details					
Mr / Mrs. / Miss / Ms / Other: _____ *(please circle one)*			Sex: Female / Male / Other: _____ *(please circle one)*		
Legal First Name:			Last Name:		
Preferred Name:			Occupation:		
Date of Birth:			Home Phone:		
Email Address:			Mobile:		
Full Address:					
Ethnic Background:	☐ NZ European / Pakeha	☐ NZ Māori	☐ European	☐ Fijian	☐ Samoan
☐ Middle Eastern	☐ Southeast Asian	☐ Indian	☐ Tongan	☐ African	☐ Tokelauan
☐ Other Pacific	☐ Cook Island Māori	☐ Other Asian	☐ Fijian / Indian	☐ Niuean	☐ Chinese
☐ I'd prefer not to say	☐ Other ethnic group (please specify):				
Are you happy to receive a text reminder of your appointments? ☐ Yes ☐ No					
Emergency Details					
Doctor's Name:			NHI Number (if known):		
Doctor's Practice:					
Next of kin name:			Next of kin relationship:		
Next of kin contact details:					
Referral and Injury Details					
Are you referred by? (please tick one)					
☐ Self	☐ Doctor	☐ Specialist	☐ ACC	☐ Employer	
☐ Other (please give details):					
Is this a work-related injury? ☐ Yes ☐ No					
If 'yes,' please specify who your employer (company name) is?					
Company Address:					
Is your employer an accredited company? ☐ Yes ☐ No *(Accredited means they cover their own workplace injuries and not ACC)*					
Health and Medical Details - *For your safety and protection, and for our information to best care for you.*					
Have you previously received physiotherapy for this condition? ☐ Yes ☐ No					
Have you ever had any major surgery? (i.e. Heart bypass etc.) ☐ Yes ☐ No					
Have you had recent surgery of any kind? ☐ Yes ☐ No					
Do you wear a hearing aid or pacemaker? ☐ Yes ☐ No					
Do you have any artificial implants – e.g., metal screws / joint replacement? ☐ Yes ☐ No					
Do you have AIDS / HIV / Hepatitis / MRSA / Notifiable Disease? ☐ Yes ☐ No					
Do you have a personal or family history of cancer? ☐ Yes ☐ No					
Are you on long term medication? Please list: ☐ Yes ☐ No					
Do you have any allergies to tape or medications? Please list: ☐ Yes ☐ No					

Have you ever been diagnosed with high blood pressure?	☐ Yes ☐ No
Do you have any serious health problems?	☐ Yes ☐ No
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?	☐ Yes ☐ No
In the past month, have you had little interest or pleasure in doing things?	☐ Yes ☐ No
In the past month, have you been feeling down, depressed or helpless?	☐ Yes ☐ No
During the past month have you been worrying a lot about everyday problems?	☐ Yes ☐ No
Are you or have you ever been a smoker?	☐ Yes ☐ No
Are you or have you ever been a vaper?	☐ Yes ☐ No

Have you had any recent / new / unusual or atypical:

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

Declaration

Consent:
I hereby give consent for an appropriately qualified provider to comprehensively assess and treat as may be necessary in the support of illness, injury or condition. I understand I have the right to decline part or all of the treatment being offered to me at any time. I understand my right to ask for a second opinion or change my treatment provider in accordance with the Code of Health & Disability Services Consumer Rights 1996.

Consent to release information to a third party:
I consent to a report or update on my condition being sent to my GP / referrer / medical centre.

I consent to relevant information being shared with third parties (this may include but not limited to: GP or other healthcare providers, Accident Compensation Corporation (ACC), Employers, insurers, or case managers) involved in your care, necessary for your treatment, rehabilitation or funding requirements.

From time to time, your clinician may use cloud-based applications to support your rehabilitation. Sports and Spinal will take all reasonable steps to protect your privacy in accordance with New Zealand legislation.

Privacy Statement:
In accordance with the Privacy Act 2020 and the Health Information Privacy Code 2020, all information recorded in your health records will be kept confidential and stored securely. Your information will only be accessed by staff involved in your care. All personnel are bound by strict confidentiality obligations. You have the right to access and request correction of your personal information held by this practice. No information will be disclosed without your consent, unless required or permitted by law.

Agreement to Pay:
I understand and agree that:

- Payment is required at the time of treatment. I am responsible for payment of any private treatment fees or co-payments for ACC appointments, including where claims are declined by ACC or another funder/insurer.
- Any unpaid accounts may be referred to a debt collection agency and you will be liable for any collection costs.
- If I fail to attend an appointment or cancel with less than 4 working hours' notice, I may be charged a $40.00 Did Not Attend (DNA) fee, payable within 14 days of invoice.
- I agree to pay for any goods or materials supplied to me (splints, orthotics, tape, products, etc).

Signature: **Date:**

(Parent / Guardian signature is required if under the age of 16 years old).

Parent / Guardian Name:

Parent / Guardian Relationship:

If you wish, our staff can provide you with a copy of this form and we will also keep it in your file and can print it for you at any time.