GOONELLABAH PHYSIOTHERAPY CENTRE 581 Ballina Road Goonellabah NSW 2480

We are committed to providing our clients with the best care, to do this it is essential that your health records are up to date and accurate. *Could you please assist us by completing in the white area, the following:*

Title (please circle)	Dr Mr Mrs Ms Miss Master Professor
Surname	
First Name	Middle Name
Date of Birth	
Street Address	
Suburb	Post Code
Home Phone	
Work Phone	
Mobile Phone	
Email	
	Do you consent to your physiotherapist contacting you via this email regarding your treatment? □ Yes □ No
Occupation	
Dept. Of Veterans' Affairs	Gold / White (please circle) Card No: Expiry Date
Health Fund □ Yes □ No	*If Yes - Health Fund Name:*
Referring Doctor - GP (*Please circle*) - Surgeon - Consultant	Name/s:
Next of Kin	(Name and Phone number)
Emergency Contact	(Name and Phone number of the person we can contact if needed)
Workers Compensation OR Third Party Insurance OR Department Of Defence Workers Comp Injury / Employer	Insurance Co. Name Case Manager: Ph No: Fax No: Employers Name: Ph. No: Contact Person at Employ:
Claim Number OR Service Number	
Date Of Injury	
Allergies eg: tape, nuts	

Workers Compensation / Motor Vehicle Accident Claims:-

*In the event of disputed liability regarding this injury, I understand that I will be personally responsible for consultation fees and equipment.

*I will endeavour to cancel any appointments I am unable to attend within a reasonable time, **or pay a $50.00 missed appointment fee.**

*Signed*____*dated*___________________

Your **Personal Health Information and your Health Record** may be collected, used and disclosed for the allied health professionals:

For follow up reminder / recall notices
Accounting / Medicare / Health Insurance procedures
Quality Assurance activities such as accreditation
For disease notification as required by law (eg; infectious diseases)
For use by all physiotherapists in this practice when consulting with you
For legal related disclosure as required by a court of law (eg; subpoena, court order, suspected child abuse)
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 pleases discuss these with you physiotherapist or receptionist.
This practice adheres to National Privacy Principles (www.privacy.gov.au)

Your signature below allows us to obtain information and to liaise with your Referring Medical Practitioner + other Health Practitioners directly involved / Insurance + Rehab case managers, concerning your condition.
Such as – **Obtaining medical information, details of previous consultations and results of investigations performed from other medical practitioners, hospitals and health care providers that pertain to your medical condition.**

Do **you consent to the use of your de-identified health information used by our practice/physiotherapists for research purposes?**

□Yes □ No

□ ***Please indicate if you do not understand any matters pertaining to this consent***

Do you have an implanted cardiac pacemaker?

□Yes □No

How did you find out about us?

□ Dr Referral □ Friend □Other____
□ Repeat Patient □ Google
□ Family Member □ Goonellabah Physiotherapy Centre Website

Australia is a genuinely multicultural society. To tailor appropriate care, encourage understanding and appreciation between people from different nationalities and backgrounds-Do you identify as someone from a culturally and/or linguistic diverse background?
Yes – Please elaborate..

If you are unable to attend an appointment, a call to cancel is appreciated as we have a busy waiting list and need time to organise another patient to have your appointment spot.
******** A $50 missed appointment fee may be requested IF you do not call to cancel within a reasonable time frame.***

Signature________________________Printed Name:__________________________Date________

Note: If signing on behalf of a patient, please print your name & relationship: _________________________