PATIENT INFORMATION SHEET

Surname: _____ **Given Names**: _____

Address:_____

Suburb:_____ **Post Code:**_____

Telephone (w) _____ **(h)**_____ **(m)**_____

Occupation: _____ **Date of Birth:** _____

Email: _____ **Health Fund**: Yes/No _____

Get Results Physical Therapy will under no circumstances sell, trade or rent any personal information that you supply to us to any third party.

What area of the body are we treating today _____

GP details	**Referral Yes/No**
Doctors Name: Address:	
	Do you approve correspondence to your GP regarding your treatment Yes/No

How did you hear about this clinic? (please tick)					
Doctor Referral		Shopping at MarketPlace		Griffith University	
Specialist Doctors Referral		Aust Physio Assoc Website		NRMA	
Family/Friend		Need a physio Website		Sporting Club	
Front Signage		Internet Search		Other (Specify)	
Gold Coast Aquatic Centre		Southport Tennis Club			

Please note below if applicable

Is this a Workers Comp Claim Yes/No Pls supply Dr's referral & W/Cover Certificate		Are you covered by Veterans Affairs Yes/No
Third Party Claim Yes/No Pls supply Dr's referral & W/cover Certificate		GP referred EPC – Enhance Primary Care Plan Yes/No
Further paperwork will be required for all Workers Comp/ Third Party/DVA Claims and EPC Care Plans.		

Would you like any information on the other services we provide at our clinic? (please tick)							
Pilates		Massage Therapy		Hydrotherapy		Exercise programmes	

Terms and Conditions:

Payment is required at time of Consultation.
I understand that I will be personally responsible for all fees on my account.
A cancellation fee of $45.00 applies if I do not give 12hrs notice of cancellation.
Full consultation fee may be charged if appointments are missed without notice.
If you are running more than 10minutes late you may have to re-schedule the appointment – please call the clinic. An administration fee of $7.50 will be charged for outstanding accounts of 30+days.

I ACCEPT THE ABOVE TERMS AND AGREE TO ABIDE BY THEM:	
Patient's/Guardian's Signature:	DATE:

THE ULTIMATE RESPONSIBILITY FOR COMPENSABLE ACCOUNTS LIES WITH THE PATIENT

Signed: _____ Date: _____

WORKERS COMPENSATION ONLY – FILL IN ALL APPLICABLE INFORMATION

Employer: _____ Insurer: _____

Employer Phone No. : _____ Date of Accident: _____

Case Manager: _____ Claim No: _____

Direct Telephone No. : _____ Solicitor: _____

I, _____ hereby authorise any professional staff member of Get Results Physical Therapy to divulge my employer and/or employers insurer, information in relation to my workers compensation claim which he/she may have acquired with regard to myself.

Signed: _____ Date: _____

MOTOR VEHICLE CLAIMS – FILL IN APPLICABLE INFORMATION

Insurer: _____ Claim No.: _____

Date of Accident: _____ Claim Manager: _____

Solicitor: _____ Telephone: _____

Solicitors Address: _____

Please read the following and indicate you understand these warnings with your signature

Heat Treatment:
When receiving heat treatment all you should feel is mild, comfortable warmth. If you feel any more than this, or if the heat concentrates in any particular spot, you must call your physiotherapist immediately, otherwise you may be in danger of being burned.

Electrical Stimulation:
When receiving electrical stimulation any concentration of the current of discomfort or pain must be reported immediately to your physiotherapist otherwise you may be in danger of sustaining an abnormal skin reaction. This may result in skin and tissue damage.

Signed:_____Date:_____