Body in Motion Physio & Rehab

Client Consent Information Form

Office Use Only:

ENTERED:
GP EVENT:

SECTION 1 - PERSONAL INFORMATION	
TITLE /GENDER:	**PHONE:**
FIRST NAMES:	**WORK PHONE:**
PREFERRED NAME:	**MOBILE:**
LAST NAME:	**EMAIL:**
DATE OF BIRTH:	**HOME ADDRESS:**
ETHNICITY: Eg NZ European, Maori	
NAME OF GP:	**MEDICAL PRACTICE:**
NAME OF SPECIALIST:	**EMPLOYER ADDRESS:** **Work Intensity:** ☐ Sedentary ☐ Light ☐ Medium ☐ Heavy ☐ Very Heavy
OCCUPATION:	
EMPLOYER NAME:	

WHY DID YOU CHOOSE BODY IN MOTION PHYSIO?		
☐ GP/Specialist/Health Profession Name: ……..	☐ Word of Mouth/Family/ Friend Name: ……. ……	☐ Work/Employer Name: ……. ….
☐ Been Before	☐ Local Directory/Yellow Pages	☐ Google/Website
☐ Signage/Location	☐ Radio	☐ Facebook
☐ Mount Joggers	☐ Newspaper	☐ Uno Magazine
☐ Other please specify: ……. ……		
We have a text message reminder service – please tick here if you would like to opt out: ☐ Do not remind		

SECTION 2 - GENERAL HEALTH QUESTIONNAIRE:		
☐ Pregnant ☐ Physical disability ☐ Diabetes ☐ Hep C/ HIV ☐ Artificial Implants	☐ Heart problems ☐ Skin condition ☐ Cancer ☐ Pacemaker ☐ Other (Specify) …….. ……	☐ Circulation/Vascular Problem ☐ Asthma/Respiratory/ Breathing ☐ Hearing/sight impaired ☐ Allergy (Specify) …….. ……
HAVE YOU USED OR ARE USING STEROIDS ☐ **ANTICOAGULANTS** ☐ **OTHER MEDICATIONS:**		

ACC45 SECTION 3 – If Non ACC please state injury site in 'How did injury happen?'

Is this an ACC Injury? ☐ YES ☐ No	**ACC 45 or Claim #:**	**DATE OF INJURY:**
Have you had physio on this claim? ☐ YES, how many …… ☐ No	**TIME OF INJURY:**	**PLACE OF INJURY:** (eg Home, Work, School, Road, etc)
Location: (e.g Tauranga, Auckland)	**Work Related Injury:** ☐ YES ☐ No	**Business Owner?** If Yes – Name of Business: ☐ YES ☐ No
How did injury happen? (Describe what you were doing and where your injury is)		
Is this a work related gradual process, disease, or infection claim? ☐ YES ☐ No		
If this is work insured – please name the Insurer :		

SECTION 4 – CONSENTS:

I hereby agree to consent to treatment by an appropriately qualified Physiotherapist for the purpose for providing comprehensive physiotherapy services as may be necessary in support of my illness, injury or condition. I have been given the opportunity to read clinic information prior to treatment. I understand I have the right to decline part or all of the treatment being offered. I understand my right to a second opinion.

AGREEMENT TO PAY:

I understand that I am liable to pay for:

- Any private treatment or copayment charges for ACC treatments and/or any treatment that is declined by ACC or other funder
- If I fail to attend my appointment or cancel without 4 working hours notice I may be charged a fee of $35
- If I fail to pay for my appointment at the time of treatment I may be charged an account administration fee
- The costs of materials such as orthotics, materials, products etc

I understand that if this service requires engaging a Debt Recovery Service to recover my debt, I will be liable for any recovery fees.

CONSENT TO RELEASE INFORMATION TO A 3rd PARTY(Privacy Act 2020):

I consent to the disclosure of my records to any person/organisation necessary for the effective management of my condition.
I consent to a discharge/update report being sent to my doctor or medical centre.

ACC DECLARATION:

I DECLARE – The information I have given about this claim is true and correct and that I have not withheld any information.
I AUTHORISE – The treatment provider to lodge the claim for me. The collection and release of any information about me to the extent that this is needed to prevent future injuries, determine cover and/or assess my entitlement to compensation, rehabilitation assistance, medical treatment and/or the appropriate level of care and personal attention I should receive. ACC to contact anyone who holds relevant information, including any external agencies or service providers (such as medical practitioners, specialists, New Zealand Police and Treatment Providers, IRD, WINZ, Assessment Agencies, employers and/or witnesses to the accident).

SIGNED: **DATE:**
(If under 16 must be signed by parent/guardian)

PHYSIOTHERAPIST SIGNED: **DATE:**

READ CODE/S: **1.** For Physio to fill) **2.** **3.**	**SIDE:** ☐ LEFT ☐ RIGHT ☐ Not Applicable ☐ Main ☐ LEFT ☐ RIGHT ☐ Not Applicable ☐ Main ☐ LEFT ☐ RIGHT ☐ Not Applicable ☐ Main