



Title: _____ **First Name:** _____ **Surname:** _____

Preferred Name: _____ **Male / Female** **Date of Birth:** _____

E-Mail: _____ **Home Phone:** _____

Mobile No: _____ **Work No:** _____

Home Address: _____

Suburb: _____ **Postcode:** _____

Emergency Contact:

Title: _____ **First Name:** _____ **Surname:** _____

Relationship: _____ **Contact No:** _____

Referrer Information:

GP: First Name: _____ **Surname:** _____

Clinic Name: _____ **Suburb:** _____

Specialist: First Name: _____ **Surname:** _____

Clinic Name: _____ **Suburb:** _____

Medicare Details:

Card No: _____

Patient Ref No: _____

Exp Date: _____

Department of Veteran Affairs Details:

Card No: _____

Card Colour: _____

Exp Date: _____

How did you hear about our clinic? (Google, Facebook, Word of Mouth, Advert, GP; Specialist etc.)

Privacy Statement:

Your personal health information and your records may be collected, used and disclosed, including but not limited to the following reasons:

1. For communicating relevant information with treating doctors, specialists, insurers and other allied health professionals.
2. For use by all physiotherapists in this group practice, when consulting you.
3. For research purposes (pre-identified, meaning you are not able to be identified from information given. If you have any concerns or wish to restrict access to your personal health information, please discuss these with your treating physiotherapist.

DECLARATION: All patients please read and sign:

I understand and agree that:

1. If I am unable to attend my appointment, I will give 24 hours notice to cancel and move my appointment. If I do not cancel within the notice period, I could be charged with a non-attendance fee for my missed appointment.
2. I am required to pay on the day of my consultations. Body Logic Physiotherapy accepts cash, cheques and has EFTPOS and HICAPS facilities. If my account is not paid at the time of my consultation, administration fees may be applied.
3. In the event that my accounts are outstanding for longer than 45 days, I will be responsible for all collection fees incurred.
4. For insurance claims, I will be personally responsible for payment of all accounts incurred by me in the event that liability is denied or placed in dispute by the insurance company.
5. I consent to treatment provided by the physiotherapist.

Communication with our patients is our priority and we endeavour to only send out important information about your appointment and our clinic.

Appointment reminders are sent out via SMS

Important clinic information is sent out via email once/month. Unsubscribe option available.

Signature: _____

Date: _____