PATIENT INFORMATION

Dr Mr Mrs Ms Miss Master

Surname:.....First Name:.....

Address:.....Suburb:.....P/Code:.....

Phone (H):.....(W):.....(M):.....

Email Address:.....Date of Birth:.....

Emergency Contact: Name:..... Relationship:..... Phone:.....

Name of Doctor:.....Phone:.....

Clinic name:..... Address:.....

Private Health Fund Name:.....Member Number:.....

YOUR ACCOUNT

We are a private clinic and request payment on the day of your consultation. If you are working with a compensable claim (eg Workcover/Motor vehicle) you will be required to make payment of your account and seek reimbursement through your insurer.

ARE ANY OF THE FOLLOWING RELEVANT TO YOU? (Please tick)

- ☐ Cardiac Pacemaker
- ☐ Hearing Aid
- ☐ Osteoporotic/Osteopoenic
- ☐ HIV/Hepatitis/TB
- ☐ Allergy to zinc oxide tape
- ☐ Pregnant
- ☐ Recent Fever
- ☐ Recent unexplained weight loss
- ☐ Dizziness/Fainting Spells
- ☐ Vascular Disorders/DVT
- ☐ History of Cancer
- ☐ Recent Surgery

HOW DID YOU FIND OUT ABOUT US? (Please tick)

- ☐ Word of mouth: Name.....
- ☐ Referred by Doctor: Name.....
- ☐ Personal Trainer: Name.....
- ☐ Sports Club recommendation: Name.....
- ☐ Internet/Website Directory
- ☐ Family
- ☐ Practice Sign
- ☐ Other (specify).....
- ☐ Pamphlet
- ☐ Newspaper/Magazine Advert
- ☐ Mail Out
- ☐ Yellow Pages
- ☐ White Pages
- ☐ Email Advertising

PATIENT CONSENT

I have read and understood the above information and the Patient Consent (attached). I consent to the email address I have provided to be used for any correspondence including results.

Printed Name:.....

Signed Patient/Parent or Guardian:..... Date..... /..... /.....

SPINE + BODY
CENTRE OF ALLIED HEALTH

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PO Box 5760 GCMC Qld 9726

SPINE + BODY
CENTRE OF ALLIED HEALTH

Welcome to the Spine + Body Centre of Allied Health

Patient Consent

Manual therapy invariably requires physical contact between Therapist and Patient. Your treatment may include modalities such as electrotherapy, spinal traction, massage or exercise where appropriate.

Your assessment will include a thorough evaluation of your presenting complaint, its recent course, severity, onset and any aggravating or pain relieving factors.

It would be useful (although not imperative) to have access to relevant investigations such as x-rays or scans available.

During the examination and/or treatment you may be required to expose the relevant area being treated. The therapist will leave the treatment area at this time and towels or gowns will be provided if required.

You may wish to have a family member or friend with you during your consultation and we respect your wish to do so. You may also request that information regarding your treatment and management be communicated to other members of your family, sporting groups or workplace supervisors and we will do so on your authority only. All information regarding your history remains strictly confidential under all other circumstances.

Once examined, the therapist will give you a thorough explanation of the cause of your complaint and treatment options and likely outcomes. Treatment options will always be discussed with you as your consent and co-operation are a vital part of each procedure.

Manual and manipulative techniques may be regarded as normal by the therapist, however, if you feel anxious or unsure about any aspect of your treatment, please feel free to ask for further information or cease treatment until your concerns have been addressed.

Should you have any concerns following your consultation, please call and we will attend to you at the earliest available time.

We also require your consent to collect personal information about you. This practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and medical history so that we may properly assess, diagnose and treat your health care needs. We use the information in the following way

1. Administrative purposes in running our medical practice.
2. Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
3. Disclosure to others involved in your health care, including treating doctors and specialists outside this practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following the referral.