***CLIENT REGISTRATION & CONSENT FORM***

At Compass Rehab we are committed to providing our clients with the best possible care. To do this it is essential that your health records are up to date and accurate. Please assist us by completing this form.

|  |  |  |  |
| --- | --- | --- | --- |
| **PART A – ALL CLIENTS PLEASE COMPLETE AS MUCH AS YOU CAN** | | | |
| Title | Mr / Mrs / Ms / Mstr / Miss / Other: | | |
| Surname |  | | |
| First Name |  | | |
| Date of Birth |  | | |
| Street Address |  | | |
| Suburb |  | Postcode |  |
| Mobile Phone |  | | |
| Email |  | | |
| Next of Kin Name & Phone No. |  | | |
| Is this a Work Injury | NO / YES (If yes, all relevant paperwork will be required) | | |
| How did you hear about us? | Friend / Dr / Internet / Facebook / Radio / other: | | |
| SMS appt. reminders | Please tick box if you DO NOT WISH to receive appt. reminders | | |
| Referring Doctor | Name:  Practice: | | |

**We use a variety of treatment techniques to assist you in your recovery. Answering the questions below will assist us tailor your therapy.**

* Are you currently taking any medication?

Please specify - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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* Have you ever taken gentamicin? Y / N
* Do you or a family member have a history of migraines? Y / N
* Have you recently been unwell?

Please specify - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Cancellation Policy:**

We understand that at times unforeseen circumstances may occur and you may not be able to make your appointment time. We politely request that all appointments are cancelled **at least 6 hours before** the appointment time. Any cancellations with less than 6 hours’ notice or non-attendances will result in a **50% late cancellation fee.**

**Please turn over and sign**

|  |  |  |
| --- | --- | --- |
| **PART B – MEDICARE CARE PLAN CLIENTS PLEASE FILL IN BELOW:** | | |
| **Medicare number:** | **\*Ref number:** | **Expiry:** |

**Medicare Plans:**

If you are under an Enhanced Primary Care (EPC) program from your doctor you may **not have any more than 5 visits combined** to allied health practitioners (physio, dietician, podiatrist, etc.) per year. If you exceed this number, you acknowledge that you will not receive a refund from Medicare. Medicare rebates through EPC plans do not cover the full cost of treatment for Physiotherapy, therefore full fees are required at the time of treatment with the rebate paid by Medicare direct to you.

**Your personal health and your health record will only be collected, used, and disclosed for the following reasons:**

* For communicating relevant information with other treating physiotherapists, general practitioners, specialists, or other allied health professionals
* For follow-up reminder / recall purposes
* For National, State or Territory registers as requested by the government
* For National, State or Territory reminder systems
* Accounting, Medicare, or Health Insurance procedures
* For quality assurance activities
* For disease notification as required by law
* For use by other health professionals in this practice when consulting you
* For legal related disclosure as required by a court of law (i.e. subpoena, court order, suspected, child abuse)
* For research purpose (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, please discuss these with your physiotherapist or receptionist. This practice adheres to National Privacy Policies (**[**www.privacy.gov.au**](http://www.privacy.gov.au)**) and has a written policy, which is available to all clients for inspection.**

**Please Note:**

* You acknowledge that our health professionals may need to contact your referring doctor or case manager regarding your condition.
* If you currently suffer from any infectious disease you are required to inform your health professional. All information is kept strictly confidential.
* If you are a Work Cover or Third Party insured patient you acknowledge that you are responsible for any outstanding account incurred if liability is denied or placed in dispute by the insurer.
* By signing this document, you legally agree to all terms, unless otherwise indicated.

**Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**