Sport & Spinal Physiotherapy
physio massage pilates gym

your podiatry CANBERRA
podiatry orthotics general footcare

Client Registration Form

(1) Title: ☐Mr ☐Mrs ☐Ms ☐Miss ☐Other _____ First Name: _____ Surname: _____

Residential Address: _____ Suburb: _____ State:_____ Postcode:_____

Postal Address: _____Suburb: _____ State:_____ Postcode: _____

Do you identify as ☐Aboriginal ☐Torres Strait Islander ☐Aboriginal and Torres Strait Islander

Date of Birth: ____/____/____ Sex: ☐ Male ☐ Female

Tel:(home): _____ (work): _____ (mobile): _____

(fax): _____ Email: _____

Note: We require your email for communicating with you about your treatment. WE DO NOT SEND SPAM. Furthermore, we only send reward vouchers (such as Refer a Friend FREE massages) by email.

Area of Injury (eg. left knee, back etc): _____

Occupation / Study: _____ Hours per week: _____

Sport / Recreational Activities: _____

Hobbies (piano / woodwork etc): _____

(3) Were you referred to this clinic by a health professional? ☐ No ☐ Yes: Name of Referrer: _____

(4) How did you find out about us? ☐ Our Website ☐ Brochure / Flyer ☐ Google / Internet Search

☐ Facebook ☐ Other Webpage_____ ☐ Social Media ☐ Other: _____

☐ From my Friend / Family — Name:_____ ☐ From my Trainer: _____

☐ From my Sports Club/Gym: _____

(5) Have you ever seen another therapist for any previous or current injuries? ☐No ☐Yes

If yes, what aspects were you most happy about? _____

Is there anything that you were not happy about? _____

(6) Name of local Doctor: _____ **Clinic/Suburb:** _____

(7) In what ways is your current injury affecting your capacity to live life as you would like to? _____

_____

(8) What are the two main things you would like to achieve from your initial treatment TODAY?

(a) _____ (b) _____

(9) Is there any reason that it is important to you to fix this problem as soon as possible? _____

_____

Sport & Spinal Physiotherapy
physio massage pilates gym

your podiatry CANBERRA
podiatry orthotics general footcare

DECLARATION

I, _____ client's full name (or parent/guardian in case of U/16) understand and agree to the terms and conditions as stated below.

Client (or Parent/Guardian) Signature: _____ Date: ___/___/__

TERMS & CONDITIONS

Cancellation policy. We require a minimum of twenty-four (24) hours notice if you wish to cancel your appointment, or fees may apply.

The client (or parent in case of U/16) at all times understands and agrees to the following terms and conditions:
(1) Sport & Spinal Physiotherapy has full authority to release or obtain any information/documents to or from any referring medical practitioner, any referring health provider, the relevant insurance company and/or my stated legal advisor regarding my current medical condition that pertains to my treatment.
(2) Sport & Spinal Physiotherapy / Gungahlin Podiatry will provide treatment to me.
(3) I will be **at all times** responsible for payment of my account in full.
(4) I will need to provide payment of my account in full at the time of consultation until the approval for any compensation claim has been confirmed.
(5) I remain liable to pay any unrecovered amounts on demand by Sport & Spinal Physiotherapy / Gungahlin Podiatry.
(6) I acknowledge that an account administration fee of 20% of the total outstanding amount will apply for any consultations not paid at the time of consultation.
(6) If there is a delay in payment of any treatment costs by longer than 60 days, I acknowledge that a late payment fee of $25 plus GST will apply monthly.

DEBT COLLECTION POLICY
In the event where this account is not paid within our trading terms the following shall apply:
(a) Sport & Spinal Physiotherapy / Gungahlin Podiatry shall be entitled to charge a debt recovery fee of 20% of the total outstanding amount.
(b) In the event where you fail to pay the whole amount due within 7 days of being so requested to do so by Sport & Spinal Physiotherapy in writing, then we shall be at liberty to instruct a Collection Agency and or solicitors to recover the monies outstanding and you shall be liable for any costs, charges, commissions and expenses reasonably and properly payable by us to such Collection Agency and/or solicitors relating to recovery of such sum.
(c) Any money recoverable by us from you pursuant to the above clauses (a) and (b) shall be added to the amount otherwise due and shall be recoverable as a liquidated debt.

Sport & Spinal Physiotherapy
physio massage pilates gym

your podiatry CANBERRA
podiatry orthotics general footcare

1) Your visit is related to?: ☐ Comcare ☐ Workers Compensation ACT ☐ Workers Compensation NSW

☐ Public Liability ☐ Motor Vehicle Accident Insurance (Third Party)

Note for all Third Party Insurance Claimants: You will be required to pay for your treatment in the rooms at private rates and then submit your payments to the insurer for reimbursement. We can directly bill any Aquatic Physiotherapy (Hydrotherapy) and Gym Rehabilitation Programs (if required) to your insurer. For further details, please ask reception.

(2) Have you provided a letter from your insurer on company letterhead stating that liability has been accepted and that you are approved for treatment at our clinic?:

☐Yes - we can bill your insurer directly ☐No - you will be required to pay for your treatment until we receive your letter

(3) Employer details: (at time of injury)

Employer: _____ Contact Person: _____ Phone: _____

Employers Address: _____ State: _____ Postcode: _____

(4) Insurer details:

Insurer: _____ Claims Officer: _____

Claims Officer Direct Phone: _____ Claims Officer Email: _____

Insurer Fax: _____ Claim Number: _____ Date of Injury: ____/___/____

(5) Work Status

How many hours per week do you normally work? _____ How many hours per week are you currently working? ____

Normal work duties (lifting, sitting etc)_____

Are any of your current work duties restricted because of your injury? _____

COMPENSATION CLAIM DECLARATION

I understand & acknowledge that:

(a) The above information is true to the best of my knowledge

(b) I will be at all times be responsible for payment of my account in full.

(c) I will need to provide payment of my account in full until the approval for my compensation claim has been confirmed.

X Client Signature: _____ **Date:** ___/___/____

CONSENT TO RELEASE MEDICAL INFORMATION:

X I_____ authorise Sport & Spinal Physiotherapy and Your Podiatry Canberra to release or obtain any information/documents to or from any referring medical practitioner, any referring health provider, the relevant insurance company and/or my stated legal advisor regarding my current medical condition that pertains to my treatment (or that of my child/charge).

Patient (or Parent/Guardian) Signature: _____ Date: ___/___/__