Sport & Spinal Physiotherapy
physio massage pilates gym

your podiatry CANBERRA
podiatry orthotics general footcare

Client Registration Form - Insurance

(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 and special offers to you. You can unsubscribe at any time.

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: _____ ☐ Friend / Family — Name:_____
☐Workshop: _____ ☐ From my Sports Club/Gym/Trainer : _____

(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? _____

_____

Conditions of Treatment

I understand that should I cancel or not attend a scheduled Physiotherapy, Podiatry or 30 min Remedial Massage appointment without providing 24 hrs notice, that a fee of $30 will be charged and a fee of $50 will be charged for a 60 min Remedial Massage. Not attending an appointment is an inconvenience to the clinic, our other patients (we have a long waiting list), and generally means you require more treatment to recover. **For insurance claims**: I hereby acknowledge and understand that should my claim be rejected in any way that I will be responsible for payment of accounts for any and all services received.

I consent Sport & Spinal Physiotherapy and Your Podiatry Canberra contacting relevant third parties in relation to my ongoing care and treatment such as my GP. I understand this is necessary to assist with my ongoing treatment. Please read our term and conditions as stated on our website at www.sportandspinalphysio.com.au/terms-and-conditions

Patient's signature _____ **Date** _____

Gungahlin: Unit 123 Gungahlin Square 43 Hibberson St Gungahlin ACT 2912
City West: Unit 4 Melbourne Building 82 Alinga St Canberra ACT 2601
Phone: 6262 4464
Email: admin@sportandspinalphysio.com.au
www.sportandspinalphysio.com.au www.yourpodiatrycanberra.com.au

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New Client Agreement

Thank you for choosing Sport & Spinal Physiotherapy and Your Podiatry Canberra as your health provider. We truly appreciate your support and will do our absolute best to provide you with exceptional health care solutions for many years to come.

We Need Your Help

To ensure we provide you and our other valued clients with the best possible care, it is important that you understand and agree to our terms and conditions as outlined below:

1. **Be on Time**: All clients are expected to **arrive on time for each and every appointment**. We will do our absolute best to not keep you waiting also.

2. **24 Hours Notice of Cancellations**: As we are a busy and professional health provider, all clients must accept and agree to our cancellation policy. Failure to attend scheduled appointment not only disrupts your treatment progress but also takes the spot of another client who may have been able to attend in your place. If you are unable to attend a scheduled appointment **you must give us 24 hours notice**, otherwise a cancellation fee will be charged.

3. **We Appreciate Your Feedback** – at the end of your session **today you will be emailed a short feedback form** where you get the chance to let us know how our admin team and therapists managed your care. Your input is highly valued so that we can continue to improve our service.

4. **Pay at the Time of Consult** – consultation fees for all private clients are to be **paid at the time of consultation. No invoices will be given**. Workers Compensation and CTP client's invoices are sent directly to their insurer provided all necessary claim numbers and paperwork are submitted. Should the claim be rejected for any reason, all invoices become the responsibility of the client.

5. **Your Treatment Plan** – To ensure the greatest success for your treatment, we suggest booking your appointments two weeks in advance. This will also ensure that you secure appointment times that suit you.

6. **Referrals Welcomed** - We thank you in advance for any referrals to our business. If you do refer your friends and family to our practice, you will be rewarded with a **free 30 minute massage** for each referral..

Clients Name: _____: **Date**_____

Client Signature:_____ **Admin Name**:_____

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

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

NOTE: WE DO NOT HOLD ACCOUNTS FOR ANY NRMA CLIENTS AND THOSE CLIENTS WILL BE REQUIRED TO PAY AT PRIVATE RATES AT THE TIME OF CONSULTATION

Note for all Claimants: You will be required to pay for your treatment in the rooms at private rates at the time of consultation until we have written approval for treatment from the insurer.

(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**: ___/___/__