Physiotherapy Client Registration Form

Personal Details:		
Title:	First Name:	Surname:
D.O.B: / /	Address:	
Suburb:		Post Code:
Contact No Home:	Work:	Mobile:
Occupation:		Email:
Next of Kin / Name:	Relationship:	Contact No:

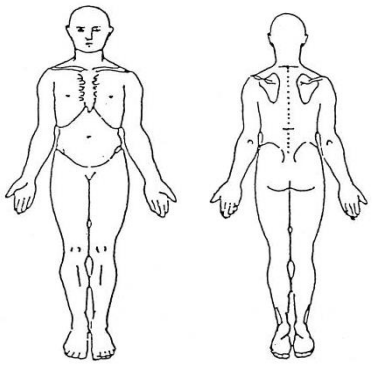
Referral Details (please tick & complete):

Source:
- ☐ General Practitioner: _____
- ☐ Friend / Relative: _____
- ☐ Google:
- ☐ Social Media: _____
- ☐ Sporting Club: _____
- ☐ Advertisement / Signage: _____
- ☐ Other:

What Is The Reason For Your Visit Today?

Reason for referral (describe your condition):

What are your concerns/ difficulties:



Medical History (please tick):

☐ Cardiac pacemaker or devices	☐ Osteoarthritis	☐ Heart disease
☐ Metal implants or screws	☐ Allergies	☐ Spinal fractures
☐ Are you currently pregnant?	☐ Diabetes	☐ Osteoporosis
☐ Cancer or tumors	☐ Neurological condition	☐ Chronic Fatigue
☐ Lung disease or asthma	☐ Arthritis / rheumatism	☐ Other health concerns

If you ticked any of the above, please describe your condition:

Suite 7, 2 Queensgate Drive Canning Vale WA 6155
Phone (08) 6162 2616
www.wahealthgroup.com.au
Physiotherapy | Exercise Physiology | Dietitian | Podiatry | Remedial Massage

Payment Method (please tick):		
☐ Private / Self	☐ Workers Compensation	☐ Motor Vehicle Accident
☐ Medicare / Chronic Disease Management	☐ Department of Veterans Affairs	☐ Other
Office Use Only		

ALL PATIENTS: Please read the following and indicate your understanding by signing and dating below

TREATMENT PRECAUTIONS

Heat: When receiving a heat treatment (heat packs or ultrasound), all you should feel is a mild, comfortable warmth. I you feel any more than this, or if the heat concentrates in one particular spot, notify your physiotherapist immediately, or you may be in danger of being burnt.

Electrical Stimulation: When receiving any form of electrical treatment, any discomfort or pain must be reported immediately to your physiotherapist, or you may be in danger of an abnormal skin or tissue reaction, which can result in tissue damage.

ACCOUNT RESPONSIBILITY & SETTLEMENT:

I acknowledge that I am responsible for the payment of any accounts incurred to myself through WA Health Group. I undertake to pay all accounts in a timely manner. I understand that any expense, cost or disbursements incurred by this practice in recovering any outstanding monies will be repaid by myself.

PRIVACY

I authorize WA Health Group to discuss my treatment and medical condition with my other treating professionals, and or insurer or employer that is responsible for my payment of my account. Our privacy statement is available on request should you wish to view this in its entirety.

CANCELLATION OF APPOINTMENT:

If you are unable to attend an appointment, please provide us with a minimum of 8 hours' notice by phone. Missed appointments may incur a non-attendance fee (full consultation fee).

CONSENT:

- I authorize for emergency medical treatment to be given to myself if necessary, in absence of family or next of kin.
- I authorize WA Health Group when required, to invoke the Freedom of Information Laws to access information that may be useful and relevant in assisting me with the services that WA Health Group provides.
- I consent to being placed on the WA Health Group contact list so that I can be kept informed of current events and information relating to the program and WA Health Group via electronic as well as standard means of communication.

PLEASE NOTE:

1. WA Health Group may give parents/guardians/ next of kin a copy of official reports and documentation, which client/parents/guardians may forward to relevant service providers.
2. As per policy guidelines of the Commonwealth of Australia's Privacy Laws, any information released or received by WA Health Group will be treated with the strictest of confidence and will not be shared with an external party except in circumstances where your written permission has been obtained; where required by a court of law; or when failure to disclose information would place you or another person at serious or imminent risk.

I have read and fully understand all of the above.

DATE: _____

NAME: _____

PATIENT SIGNATURE: _____

COMPLETE ONLY | Workers Compensation or Motor Vehicle Accident Patients Only

Insurer:	Claim No:	Date Of Injury:

SHOULD MY CLAIM NOT BE ACCEPTED BY THE INSURANCE COMPANY, I HEREBY AGREE THAT I WILL BE OTHERWISE LIABLE, AND IN AGREEMENT OF SETTLING ALL OUTSTANDING ACCOUNTS TO WA HEALTH GROUP.

Signed:	Date: / /

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