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Kathryn Milne
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Physiotherapy
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B. Physiotherapy
Provider No. 5139311K

countrywide physio
balance~strength~flexibility

Confidential Client Details

Title: Mr☐ Mrs☐ Miss☐ Ms☐ Dr☐ Male ☐ Female ☐

Surname _____

Given Names _____

Date of Birth _____

Home Address _____

Postal Address _____

Suburb/Town _____ State _____ Post code _____

Occupation_____ Ambulance Cover: Yes☐ No☐

Ph: Home _____Work _____ Mobile _____

Email _____

Emergency Contact: Name _____ Phone _____

Local GP: Name_____ **Practice** _____

Private Health Yes ☐ No ☐ **Health Fund** _____

Are You Pregnant? Yes ☐ No ☐ N/A ☐ Can you Swim? Yes ☐ No ☐

If you are claiming through Workers Compensation / Motor Vehicle Accident:

Date of Injury_____ Employer _____

Ph No_____ Address _____

Insurance Company_____ Claim No _____

Case Manager _____

Do you have a Medicare EPC (Enhanced Primary Care)? Yes ☐ No ☐

Are you with Veterans Affairs? Yes ☐ No ☐ **Card Number** _____

Are you taking Medication? Please List _____

_____

_____

What is the reason for your visit today? _____

How did you find out about this Clinic?_____

Do you have or have you ever had?: (please tick)

☐Bladder/bowel problems	☐Infective Skin Conditions	☐Open Wounds
☐Cancer	☐Pacemaker	☐Epilepsy
☐Recent unexplained weight loss	☐Diabetes	☐Stroke
☐Joint Replacements/Metal Implants	☐Heart attack	☐Neurological Conditions
☐Trauma/Fracture	☐High blood pressure	☐Arthritis
☐Respiratory conditions	☐Recent surgery	☐Hearing aid

☐Any other medical conditions not listed:_____

DISCLOSURE OF PRIVACY

All the above information is correct to the best of my knowledge.

I give permission for other service providers, such as specialists, doctors, case managers, rehabilitation consultant and/or appropriate health practitioners to have access to personal information to assist my recovery.

Signed_____**Date**_____

OFFICE POLICY

Fees Payable: It is the policy of this practice that accounts are paid on the day treatment is provided. In the event of a collection process being initiated I agree to pay all costs incurred until such time as all outstanding debts are cleared.

Third Party and Liability cases are required to pay at time of treatment.

Missed Appointments: missed appointments will set you back in your recovery, so we ask that wherever possible you keep all your appointments. If an appointment must be changed, 24 hours notice is appreciated. If less than 24 hours notice is given for a cancellation, a fee may be charged. Consideration will be given for unavoidable circumstances. All missed appointments must be rescheduled within 24 hours to avoid a cancellation fee. **This fee is not covered by compensable bodies and must be paid by the patient.**

Mobile Phones: Out of respect and courtesy for others and our practitioners, please turn off your mobile phone in the waiting area and during consultations.

Appointment Scheduling: Your physiotherapist will outline a recommended action plan as the best plan for your injury. You will achieve the maximum results when you keep your recommended action plan to this schedule. Therefore, to receive the most out of your care and to save time we ask that you schedule your appointments in advance.

I have read and fully understand the above Office Policy.

Signed_____**Date**_____