PATIENT INFORMATION FORM

❑ Mr ❑ Mrs ❑ Miss ❑ Ms: First Name:		Middle:
❑ Other _____	Last Name:	Preferred:
Street Address:		DOB: / /
		Gender: ❑ M ❑ F
Postal Address: (Please tick if same as Street Address ❑)		
Home Phone:	Mobile:	Work Phone:
Email:		Occupation:
Concession: ❑ Yes ❑ No Card No #:		Expiry Date: / /20

Appointment Reminder Service Would you like to receive appointment reminders by **SMS**? ❑ Yes ❑ No Thanks

Would you like to book your future appointments **online**? ❑ Yes ❑ No Thanks

PLEASE SELECT PATIENT TYPE: ❑ Private Patient (Please go to Section 2)

❑ MVA or ❑ WorkCover or ❑ Under 18 years old (Parent/Guardian)Please complete the following:

SECTION 1 - BILLING INFORMATION

❑ Mr ❑ Mrs ❑ Miss ❑ Ms ❑ Other ____: First Name:		Last Name:
Organisation Name (if applicable):		Injury Date: / /20
Case Manager (if applicable):	Claim No#	Employer:
Postal Address:	Phone:	Fax / Email:

SECTION 2 - ADDITIONAL INFORMATION

Medicare No #:		Patient ID No #:	Expiry Date: / /20
Private Health Extras: ❑ Yes ❑ No	Name of Private Health Fund :		
	Member No #:		Patient ID No #:
DVA : ❑ Yes ❑ No	Card Type: ❑ White ❑ Gold	DVA File No #:	Expiry Date: / /20
Who is your GP/ Specialist? Dr Name:		Clinic Name:	
Address:		Phone:	Fax: / Email:
Do you have a Doctor's Referral? ❑ Yes ❑ No		Type of Referrer: ❑ GP ❑ Ortho ❑ Specialist	

SECTION 3 - EMERGENCY CONTACT

❑ Mr ❑ Mrs ❑ Miss ❑ Ms ❑ Other ____ : **First Name:** **Last Name:**

Contact Phone #: **Relationship to you:**

SECTION 4 - Who can we thank for telling you about us? (Please specify where applicable)

❑ Family / Friend ***who:***	❑ Doctor ***who:***	❑ Sporting Club ***who:***
❑ Previous Patient	❑ Brochure/ Flyer	❑ Passing By / Signage
❑ Search Engine	❑ My PhysioSA Website	❑ Facebook/ Twitter
❑ HCF More for Muscles	❑ Health Partners	❑ Other :

****PLEASE TURN OVER & COMPLETE THE NEXT PAGE****

MISSED APPOINTMENT POLICY

Please advise us at least 4 hours prior to your appointment time.

COVID VACCINATION STATUS

Have you had a Covid-19 Vaccination? Y/N
If yes: 1st 2nd 3rd booster (circle)
Date of last dose: _____

PRIVACY STATEMENT

In regard to Privacy Laws, some of the information you have given will be provided to Medicare as part of the billing and medical rebate process. It may also be used for providing information to your Private Health Fund where appropriate. The Practitioners in this Practice will pass on information about your medical condition to your referring General Practitioner, Specialist or various medical bodies, in accordance with your consultation. At other times, your personal details and medical history are confidential between you and your Practitioner in this Practice and will not be released to anyone else, including family members, without your written consent.

Do you give Staff permission to speak to the person who answers your contact telephone should it be necessary to contact you? ❑ **Yes** ❑ **No**

AUTHORITY – ALL PATIENTS

- The provided information is true to the best of my knowledge.
- I authorise my insurance benefits be paid directly to the therapist via HICAPS.
- I understand that I am financially responsible for any balance.
- We ask that you pay the full fee for your consultations, products and services at the reception desk – directly after you have seen your therapist

MVA /Workcover Claim - Authority

- I also authorise myPHYSIOsa or insurance company to release any information required to process my claims.
- I authorise myPHYSIOsa to discuss confidential information, relevant to my injury with my GP/Specialist, employer and other medical providers.
- By signing below I am giving my Physio permission to exchange information relevant to the management of my rehabilitation and/or return to work.
- Irrespective of the outcome of any compensable claim, I accept full responsibility for the full payment of my account.

By signing below, I agree to be sent relevant clinic information by **monthly newsletter** to my email account.

Please tick to opt out ❑

_____ _____ _____

Signature (Patient OR Parent/Guardian) Print Name Date

OFFICE USE ONLY	❑ New Patient ❑ Existing Patient Update	❑ Mt B ❑ PH
Fee Category:- ❑ Standard ❑ DVA ❑ Medicare ❑ NAFC ❑ Concession		
❑ MVA ❑ Work Cover CLAIM Approval:- ❑ Yes ❑ No ❑ Pending		**COMPLETED:- ❑ FD ❑ Scan**
APPT REMINDERS: ❑ No ❑ Yes ❑ Entered on Patient File		
ONLINE BOOKINGS: ❑ No ❑ Yes ❑ Log-On Request Sent		