Celia Monk Physiotherapy

Client Consent and ACC Information Form

Office Use Only:

ENTERED: ☐

SECTION 1 - PERSONAL INFORMATION

TITLE:	**PHONE:**
FIRST NAME:	**WORK PHONE:**
PREFERRED NAME:	**MOBILE:**
LAST NAME:	**EMAIL:**
GENDER: ☐ **MALE** ☐**FEMALE**	**HOME ADDRESS STREET:**
DATE OF BIRTH:	
ETHNIC GROUP:	
NAME OF GP:	**SUBURB:**
MEDICAL PRACTICE:	**CITY:**
OCCUPATION:	**POST CODE:**
EMPLOYER NAME:	**EMPLOYER ADDRESS:**

HOW DID YOU HEAR ABOUT US :

ANY SPECIFIC CULTURAL OR PHYSICAL NEEDS YOU MAY HAVE:

SECTION 2 - GENERAL HEALTH QUESTIONNAIRE:

☐ Pregnant	☐ Heart condition	☐ Hearing/sight impaired	☐ Asthma/Respiratory
☐ HIV/Hep C	☐ Stroke/TIA	☐Osteoporosis/bone weakness	☐ Skin condition
☐ Surgery within last 5 years ……	☐ Cancer	☐ Other (Specify) ……..	☐ Allergy (Specify) ……
	☐ Smoker		

MEDICATIONS – PLEASE LIST:

SECTION 3 - ACC CLAIM INFORMATION

☐ Private Patient **Do not** complete this section	☐ ACC – Claim Registered	☐ ACC- New Injury Claim	☐ Other Insurer/Accredited Employer

INJURY SITE/S (e.g. Left Knee)	**READ CODE/S:** Physio to complete	**ACC CLAIM NUMBER:**

CAUSE OF INJURY:
Describe what you were doing
e.g. Lifting carton from car and hurt lower back

DATE OF INJURY:	**TIME OF INJURY:**	**WORK RELATED INJURY:** ☐ YES ☐ NO

WORK INTENSITY: ☐ Sedentary ☐ Light ☐ Medium ☐ Heavy ☐ Very Heavy

SCENE: e.g. Home, Work, Sport	**LOCATION:** e.g. Waikato

SECTION 4 – CONSENTS

I hereby agree to consent to treatment by an appropriately qualified Physiotherapist for the purpose for providing comprehensive physiotherapy services as may be necessary in support of my illness, injury or condition. I consent for my anonymous data to be used for research purposes, understanding I will not be identified at all. I have been given the opportunity to read clinic information prior to treatment. I understand I have the right to decline part or all of the treatment being offered. I understand my right to a second opinion. I understand I may have a chaperone/support person present if I want.

AGREEMENT TO PAY:

I understand that I am liable to pay for treatment if:

- It is not covered by ACC
- If any treatment is declined by ACC or other funder
- For the costs of materials such as rolls, books etc

I understand that payment for each treatment is due at the time of the appointment and the clinic has a no credit policy.
I understand that in the event this service needs a Debt Recovery Service to recover my debt, I will be liable for any recovery fees.

CONSENT TO RELEASE INFORMATION TO A 3rd PARTY

I consent to the disclosure of my records to any person/organisation necessary for the effective management of my condition.
I consent to a discharge/update report being sent to my doctor or medical centre.

ACC DECLARATION

I DECLARE: That the information I have given about this claim is true and correct and that I have not withheld any information likely to affect my application.
I AUTHORISE: The collection and release of any information about me to the extent that this is needed to prevent future injuries, determine cover and/or assess my entitlement to compensation, rehabilitation assistance, medical treatment and/or the appropriate level of care and personal attention that I should receive.ACC to contact anyone who holds relevant information, including any external agencies or service providers (such as medical practitioners, specialists, New Zealand Police, and Treatment Providers, IRD, WINZ, Assessment Agencies, employers and witnesses to the injury

SIGNED: **DATED:**
(If under 16 must be signed by parent/guardian)