PODIATRYMED
& PHYSIOTHERAPY

Patient Consent and Information Form Private and ACC

PERSONAL INFORMATION			
FIRST NAMES:		PREFERED NAME:	
LAST NAME:		GENDER:	M / F *Circle one*
DATE OF BIRTH:		OCCUPATION:	
ETHNICITY:		WORK DETAILS:	
CONTACT DETAILS			
ADDRESS:		PHONE:	
SUBURB:		MOBILE:	
CITY:		EMAIL:	
POST CODE:		GP:	
Would you like your yearly Orthotic reminder by: ☐ Email ☐ Post		Would you like us to keep your GP informed: ☐ Yes ☐ No	
REFERRAL DETAILS			
How did you find out about PodiatryMed?		Name of Referrer:	

Reason for coming to Podiatrymed?

GENERAL HEALTH QUESTIONS

Please let us know your existing health condition that we should be aware of *(please tick all that are relevant)*

☐ Pregnant	☐ Skin condition	☐ Sight Impaired	☐ Artificial implants
☐ Physical disability	☐ Cancer	☐ Hep / HIV	☐ Allergy
☐ Diabetes	☐ Pacemaker	☐ Circulation/ vascular	☐ OTHER, please specify
☐ Heart Problems	☐ Hearing impaired	☐ Asthma/Respiratory	....

NEW ACC DETAILS AND EXISTING CLAIMS! (please fill in all fields)	
Is this an ACC Injury ☐ YES ☐ No Private	**ACC Claim No (if known):**
Date of Injury: **Time of injury:**	**Read Code/s:**
What is your injury? & How did injury happen? (please describe)	**What side is the injury?** ☐ Left ☐ Right ☐ NA
Location: (e.g. Christchurch, Auckland)	**Place of Injury**: e.g. Home Work etc
Have you had treatments on this claim previous? Y / N	**If claim is already registered, is it less than 52weeks old? Y / N**
If work injury give work details:	

CONSENT FOR TREATMENT (please read before signing)

I agree to consent to treatment by an appropriately qualified Podiatrist/Physiotherapist for the purpose of providing comprehensive podiatry/physiotherapy services as may be necessary in support of my illness, injury or condition. 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 agree that all information given is true and correct.**

AGREEMENT TO PAY (Please read before signing)

I understand that I am liable to pay for:

- **Any private treatment or co-payment charges for ACC treatments at the time of the appointment!**
- **Less than 12hrs working notice of cancellation or not showing up for an appointment will incur a charge of $25**
- **Failure to pay at the time of treatment will incur a $10.00 account fee, and each month not paid will incur further fees**
- **Any treatment that is declined by ACC or other funder will be charged at the Private rate and the difference is required**

The costs of materials such as orthotics, materials, products etc

CONSENT (I have read and understood both consent and agreement sections)	
PATIENT SIGNATURE: *(If under 16 must be signed by parent/guardian)*	**DATE:**
CLINICIAN SIGNATURE:	**DATE:**