PODIATRYMED
& PHYSIOTHERAPY

NEW and RETURNING Patient Consent and Information Form Private and ACC

PERSONAL INFORMATION (Please print clearly)			
FIRST NAMES:		LAST NAME:	
PREFERED NAME:		GENDER:	
DATE OF BIRTH:		OCCUPATION:	
ETHNICITY:		NHI (if known):	

CONTACT DETAILS (Please print clearly)			
ADDRESS:		PHONE:	
SUBURB:		MOBILE:	
CITY:		EMAIL:	
POST CODE:		GP:	
Would you like your yearly Orthotic reminder by: ☐EMAIL		Would you like us to keep your GP informed: ☐ Yes ☐ No	
* Emergency contact (name, relationship and phone Number):		*	

REFERRAL DETAILS

How did you find out about PodiatryMed? Name of Referrer:

Do You Have Any Cultural or Specific Needs? (i.e disposal of waste products) please list below:

GENERAL HEALTH QUESTIONS

Please let us know your existing or past health condition/s 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	.....

MEDICATIONS

Please let us know of any current medications that we should be aware of *(please list below)*

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 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 the appointment cost.**
- **Failure to pay at the time of treatment will incur a $20.00 account fee and an invoice given to pay within 7 days, if payment is not received within 60 days we will engage a debt collector and you will be liable for costs incurred.**
- **Any treatment that is declined by ACC or other funder will be charged at the Private rate and the difference is required**
- **Any costs for orthotics and materials declined by ACC.**

CONSENT (I have read and understood both consent and agreement to pay sections)

PATIENT SIGNATURE: *(If under 16 must be signed by parent/guardian)*	**DATE:**
CLINICIAN SIGNATURE:	**DATE:**

ACC Details *(Please sign consent on front)*

(New or already registered claims through ACC insurance must be discussed with your practitioner at the time of the initial consultation)

Is this a new ACC ☐ YES / Is this an existing ACC ☐ YES	**ACC Claim No (required if registered):**
Date of Injury:	**Read Code/s:**
What is your injury? & How did it happen? (please describe)	**What side is the injury?** ☐ Left ☐ Right ☐ NA
Location: (e.g. Christchurch, Auckland)	**Place of Injury**: (e.g. Home, Work)
If work injury give work details: (e.g. Name, address)	

OFFICE USE ONLY

By Provider Approval Only

ACC Orthotic Contract ☐ Tick yes

Orthotics $145 (Purple $155)

RED / XXS XS S M L XL XXL (circle one)

BLACK / XXS XS S M L XL XXL (circle one)

PURPLE/ XXS XS S M L XL XXL (circle one)

Size - XXS XS S M L XL XXL (circle one)

Type – Cushion Red Control Black Dual Density ¾ Dual foam/Green

Heel Raises $20

Sml Med Large High/Low

Single 1 pair 2pairs 3pairs 4pairs

Moonboot/Ankle Brace/Knee Brace S M L $115

Patient agreement as obligation to pay private charges (full cost) if ACC is declined.

I understand that if ACC declines my claim or declines the Orthotics or Heel Raises from a current claim, I am obligated to pay the full cost of the orthotics within 7 days of being invoiced by PodiatryMed Ltd

Sign: _____ Date: _____