

Patient Details

Patient Name _____ D.O.B _____ Age _____

Address _____

Phone _____ Fax _____ Mobile _____ Email _____

Employer _____

Job description _____

Phone _____ Fax _____ Mobile _____ Email _____

Area to be treated _____

Date of Injury or Onset _____

Medical History Questionnaire

Yes / No

Yes / No

Could you be or are you pregnant?		
Do you now or have you ever had any of the following conditions?		
Arthritis		
Diabetes		
Numbness / Tingling		
Osteoporosis		
Anemia		
Fever / Chills		
High Blood Pressure		
Hypersensitivity to Heat/Cold		
Thyroid Problems		
Heart Disease		
Swelling in Ankles		
Headaches		
Heart Attack		
Deep Vein Thrombosis (DVT)		
Head Injury / Concussion		
Pacemaker Seizures / Epilepsy Hernia		
Vascular Disease		

Metal in Body or Surgical implants		
Kidney / Bladder problems		
Stroke Cancer / Tumor		
Previous Fractures		
Asthma		
Recent Weight Loss or Gain		
Previous Surgeries		
Shortness of Breath		
Fatigue / Weakness		
Hearing Loss		
Chronic Cough		
Tuberculosis		
Depression		
Dizziness / Light Headedness / Fainting Spells		
Recurrent Infection(s) or		
Infection in past 3 months		
Anxiety		
Nausea / Vomiting		
Hepatitis		
Substance Abuse		

If you answered "yes" on any of the above or have other conditions not listed, please explain and give approximate date(s): _____

Do you have any allergies? If Yes, list allergies: _____

Are you presently taking any medications? If Yes, list medications and specify condition: _____

At the present time, would you say that your health is (*circle one*): Excellent Very Good Fair Poor
 The information is correct to the best of my knowledge. *Please sign below.*

Patient/Parent/Guardian Signature _____ Date _____

Please indicate how you came to know about PHYSIOPRO (*circle one*): Hospital Newspaper Magazine Doctor Sports Club Friends Family Internet

Other _____

Patient Claim & Consent

Are you intending to claim the costs of your treatment from:

Workcover NSW, Medicare, DVA or any other third party insurer? Yes / No .

If Yes, please provide the following details (where relevant):

CTP Claim:

Name of Insurance Company _____ Claim Number _____

Workers Compensation:

Employer's name: _____

Name of employer's Insurance Company

Contact person's name at workplace _____

Phone no. _____ Fax _____ Email _____

Claim Number(if provided) _____

Case Manager(if known) _____

DVA Patient- Gold / White Card (please circle)

Patient Authorization

Release of Information & Consent for Treatment

All information provided herein is true and correct.

I wish to receive treatment from PhysioPro.

I permit its employees and all other persons caring for me to treat me in ways they judge are beneficial to me.

I understand that this care can include an evaluation, testing and treatment. No guarantees have been made to me about the outcome of this care. I give permission to PhysioPro and affiliates to release information, verbal and written, contained in my medical record, and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries and all other related persons as it relates to my treatment and/or payment for services provided.

I authorize PhysioPro and/or its affiliates to obtain medical records and/or professional information from my physician or other medical professional as it relates to my treatment.

The signature below certifies that I have read and understand the above information.

Assignment of Benefits

I authorize payment directly to PhysioPro and/or affiliates for services and to bill and release payment directly to PhysioPro and/or affiliates for any physiotherapy, occupational therapy, speech-language pathology, rehabilitation, orthotic or prosthetic services provided. This is a direct assignment of my rights and benefits under this policy. A photocopy of this assignment shall be considered as effective and valid as the original.

Notice of Privacy Practices

I hereby acknowledge that I have received a copy of The Notice of Privacy Practices for PhysioPro.

In addition, I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment, and health care operations.

Payment Guarantee

I agree to pay PhysioPro for the services provided to me or the party named above. If any law, such as workers' compensation, or insurance contract prohibits payment for these services I will cooperate and assist in the provision of information, authorizations, releases, or any other type of information necessary to allow for speedy collection from my third-party payer. Where the law or an insurance contract does not prohibit payment by me, I acknowledge responsibility for any and all account balances. The Benefit Verification form is only an explanation of coverage obtained from my insurance company and it is not a guarantee of coverage. If the information provided by my insurance company is not accurate or the insurance company changes its coverage, I will be responsible for payment for services.

I further understand that this agreement is binding regardless of any legal transaction currently in progress or initiated during or after the course of my treatments unless agreed to in writing by myself and a representative of PhysioPro.

Printed Name _____

Patient or Guardian Signature: _____ Date: _____