New Patient Details

Personal Information:

Surname: …….. First Name: ……..

Address: ……..

Suburb …… Post Code: ……

Phone: ..... Email: ……

Date of Birth: …… Occupation: ……..

Emergency Contact:

Name …… Mobile: ……

Referral Details:

How did you find us: ……...

Medical History:

Family Doctor ……. Clinic Name ……

Do you currently suffer with any medical conditions? Yes / No

If yes, please discuss details / medication with the physiotherapist. If you have a metal implant or a cardiac pacemaker, please inform the physiotherapist.

Payment Details:

* *Physiotherapy and massage are not covered by Medicare*

- PRIVATE PATIENT ☐ **Health Insurance Fund** ……..
- HEALTH CONCESSION CARD ☐

Billed directly:

- DVA (Veterans Affairs) ☐
- WORK COVER ☐ MOTOR ACCIDENT ☐

Claim No: ……..

Claim Manager: …… Tel: ……

Claim Manager E-Mail Address ……

EPC (Care Plan) ☐ * $30 surcharge for Initial Consultation

* $20 surcharge for Follow-up Consultations

Medicare Number ……Identifier No:…….. Expiry:……

*Full payment will be processed at time of appointment; We will process your Medicare Card and a rebate will be credited to your nominated Bank Account

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Payment is due on the day of treatment: Cash, EFTPOS and / or HICAPS

New Patient Details

Agreement to Treatment/ Privacy Policy / Information Release & Cancellation Policy

I agree to:

- Examination & treatment at SportsPhysioSA
- The SportsPhysioSA Privacy & Information Policy (available on website or hard copy)
- The SportsPhysioSA Cancellation Policy (available on website or hard copy)

Cancellation Policy Summary

SportsPhysioSA is committed to providing a high quality and accessible service.

Unfortunately, when a patient fails to attend or cancels without giving enough notice, they prevent another patient from being seen.

Please reply to the SMS reminder if you are unable to attend or call us on 8356 6965 by 2:00 p.m. on the day prior to your scheduled appointment to notify us of any changes or cancellations.

If prior notification is not given, we will charge **$40 for missed appointments / $20 for missed group exercise sessions**. Exceptions may be made in extenuating circumstances.

Signed: …….. Date: …… / …… / ……

If patient is under 16 years, name and signature of Parent / Guardian is required:

Name: …….. Relationship: ……..

Signed: …….. Date: ……. / …… / ……..

Payment is due on the day of treatment: Cash, EFTPOS and / or HICAPS