Sportreat TotaLife Care

your health matters

Patient Registration Details

A part of the Total HealthCare Group Pty Ltd

ABN 14 081 380 976/002

367 Canning Highway
Palmyra WA 6157

PO Box 491
Melville 6956

P 08 9438 2400
F 08 9438 2900

info@sportreat.com.au
sportreat.com.au

□ Mr □ Mrs □ Ms □ Miss □ Master □ Dr

Surname: _____

Given Names: _____

Preferred Name: _____

Address: Number/Street _____

Suburb _____ Post Code_____

Date of Birth: ___/_____/_____

Phone (H): _____ Phone (W):_____

Mobile: _____ Email: _____

Occupation: _____

Next of Kin: _____

Address: Number/Street:_____

Suburb: _____Post Code_____

Phone: _____

General Practitioner: _____ Practice Name: _____

Referring Doctor: _____

Private Health Fund: _____ Membership Number: _____

Medicare Number: _____ Exp ___/20___ Ref Number _____

Veterans Affairs Number:_____Pensioner Number_____

Where did you hear about us?

□ Friend/Relative – Name: _____ □ Doctor □ Advert

□ Internet/Google □ Employer □ Other: _____

Medical History

Do you have a cardiac pacemaker or any other devices? □ Yes □ No

Do you have any metal implants? □ Yes □ No

Are you currently pregnant? □ Yes □ No

Do you/have you had any of the following health problems?

Cancer/Tumor	□ Yes	□ No	**Spinal Fractures**	□ Yes	□ No	**Osteoporosis**	□ Yes	□ No
Heart Disease	□ Yes	□ No	**Ross River Virus**	□ Yes	□ No	**Meningitis**	□ Yes	□ No
Arthritis	□ Yes	□ No	**Lung Disease**	□ Yes	□ No	**Diabetes**	□ Yes	□ No
Allergies	□ Yes	□ No	**Chronic Fatigue**	□ Yes	□ No	**Stroke**	□ Yes	□ No

Other _____

Your Condition

Briefly describe the nature of your condition:

_____

Have you received treatment for this problem before? □ Yes □ No

PLEASE SEE REVERSE

CANCELLATION POLICY: FAILURE TO GIVE 24 HOURS NOTICE MAY RESULT IN THE FULL CONSULTATION FEE BEING CHARGED

Who is responsible for paying your account?

(Self, parent, solicitor) Full Name: _____

Street Address: _____

Suburb: _____

Postcode: _____

Account Type

□ Standard

□ Motor Vehicle Claim Number: _____ Date of accident: ____/___/____

□ Workers Compensation Claim Number: _____ Date of accident: ____/___/____

Responsibility for accounts:
I accept that consultations are to be paid in full at the time of the visit unless this visit is related to an accepted 3rd part motor vehicle claim, the details of which are provided below. In the event of a 3rd party claim being refused by the relevant authority, I will accept responsibility for payment of any account for professional services given. I understand that any expenses, costs or disbursements incurred by this practice in recovering any outstanding monies will be repaid by myself.

Signed: _____

If you do not understand this, please discuss with reception before your consultation.

Physiotherapy Treatment Information:

Heat treatment:
When receiving heat treatment, all you should feel is mild comfortable warmth. If you feel any more than this, or if the heat concentrates in any particular spot, you must notify your Physiotherapist immediately, otherwise you may be in danger of being burned.

Electrical Stimulation:
When receiving an electrical stimulation, any concentration of the current, discomfort or pain must be reported immediately to your Physiotherapist. Otherwise you may be in danger of sustaining an abnormal skin reaction. This may result in skin and tissue damage.

Patient Consent to Collect & Disclose Information PRIVACY ACT 1988 – Amended March 2014.

The privacy ACT 1988 amended March 2014 ('The Act') requires Health Practitioners to obtain consent from their patients to collect, use and disclose that patient's personal information if required.
A copy of Sportreat's privacy policy is on display at the reception desk. Upon request, you will be supplied with a copy

CONSENT

- I acknowledge that I have been given the opportunity to read the Sportreat Information on the Privacy Act 1988.
- I provide my consent for Sportreat Health Care Providers to collect, use and disclose my personal information as outlined in the Sportreat Information on the Privacy Act 1988.
- I understand that I am entitled to access my own health records except where access would be denied as outlined in the Sportreat Information on the Privacy Act 1988.
- I understand that I may withdraw my consent as to use and disclosure of my personal information (except when legal obligations must be met).

AUTHORISATION TO PROVIDE RECORDS/RESULTS

We may need to collect relevant information regarding you from various pathology laboratories, radiology facilities, or from other doctors, specialists, or other health care providers. This authorisation will allow us to collect this information.

I ..... of .....

Hereby authorize the provision of relevant medical records and/or test/investigation results to Sportreat Health Care Providers, 367 Canning Hwy, Palmyra WA 6157.

SIGNED: ..... **WITNESSED:** .....

DATE: ...../...../ 20.....